DOCUMENT RESUME

ED 182 526 CE 024 087

TITLE	Mental Health/Human Service Worker Activities. The Process and the Products. A Report of Phase I Paraprofessional Worker Certification Project.
INSTITUTION	Southern Regional Education Board, Atlanta, Ga.
SPONS AGENCY	National Inst. of Mental Health, Rockville, Md. Paraprofessional Manpower Develcpment Branch.
PUB DATE	79
GRANT	NIMH-1-T41-MH-14520-MHST
NOTE	128p.
EDRS PRICE	MF01/PC06 Plus Postage.
DESCRIPTORS	Health Occupations Education: *Human Services; *Job Analysis: *Job Skills: *Mental Health; National Surveys; *Paramedical Occupations; *Paraprofessional Personnel
IDENTIFIERS	*Mental Health Workers

ABSTRACT

Phase 1 of the Paraprofessional Worker Certification project defined and described the content and characteristics of mental health/human service work. Empirical data collected in several earlier projects was subjected tc two forms of validation on a national basis. On a job analysis survey workers in the field indicated the frequency with which they performed tasks in the first validation. Hierarchical-grouping-statistical procedures were used to analyze these data and to group related tasks into clusters from which forty competency statement constructs were derived. A second validation of the competency statements involved obtaining scaled data which identified the relative frequence, importance to client, and potential risk to client (if poorly done) for each competency. Respondents (supervisors, educators, and workers) also identifed the level of worker currently performing each competency. Analysis of survey returns suggested that (1) the statements covered mental health/human service work completely and (2) the basis for partitioning the work into levels is weak. (Appendixes amounting to over one-half of the report include the worker activity/competency statements with statement, interpretation, context, and indicators and the job analysis survey.) (YLB)

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MENTAL HEALTH/HUMAN SERVICE WORKER ACTIVITIES

THE PROCESS AND THE PRODUCTS

A Report of Phase I

Paraprofessional Worker Certification Project

Grant No. 1 T41 MH 14520 MHST

from the

National Institute of Mental Health

CE 024 087

U S DEPARTMENT OF HEALTH, EDUCATION & WELFARE
NATIONAL INSTITUTE OF EDUCATION

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Southern Regional Education Board

130 Sixth Street, N. W.

Atlanta, Georgia 30313

1979

MAR 19 1980

FOREWORD

The Mental Health Program of the Southern Regional Education Board has been involved with a series of projects concerned with the development of paraprofessional mental health workers since 1966. At present the Southern Regional Education Board has a grant from the Paraprofessional Manpower Development Branch of the National Institute of Mental Health (Grant No. 1 T41 MH 14520 MHST) which has as its objective to develop proposed guidelines and procedures for a national program to certify mental health workers at various levels on the basis of competence rather than on the bases of academic credentials or tests of knowledge alone.

A first step in determining the competence of any kind of worker is to assess just what it is that the worker is expected to do. This assessment must be verified by what workers actually do in carrying out their jobs rather than on what "experts" believe they "ought" to do. This report describes that part of the SREB's project activity that has been carried out to develop worker activity statements of the activities actually carried out in a number of community-based and institutional mental health programs across the nation. These activity statements will now be used to define the competencies (attributes and skills) of workers that enable them to carry out these activities to achieve favorable outcomes with clients.

Most of this work was done under the leadership of Arthur L. Benton with the help of several task forces and consultants whose names appear in the Appendix.

We are grateful to all of the persons who have participated in this effort and to the National Institute of Mental Health and especially the staff of the Paraprofessional Manpower Development Branch for their support and assistance.

Harold L. McPheeters
Director
Commission on Mental Health
and Human Services

THE PROJECT AND THE SETTING

BACKGROUND

The Southern Regional Education Board (SREB), with assistance from the Paraprofessional Manpower Development branch, National Institute of Mental Health, has undertaken a project to develop a performance-based credentialing system for mental health workers -- a system which substitutes performance measures for academic credentials.

This project, along with a companion project to develop an approval system for the academic programs which prepare mental health/human service workers for entry into the manpower system, culminates 10 years of developmental work at SREB under the leadership of the Commission on Mental Health and Human Services.

Earlier efforts have been documented in SREB publications -- Roles and Functions for Mental Health Workers, 1969, Plans for Teaching Mental Health Workers, 1971, Introduction and Use of Associate Degree Workers in the Mental Health System, 1973, and A Guidebook for Mental Health/Human Service Programs, 1976.

As this project commenced in September 1976, issues of the Sixties were giving way to other, more contemporary problems. Programs, such as "New Careers" and similar manpower development programs, were being re-evaluated. Deinstitutionalization was becoming a major new theme in the mental health system.

Among the more important health-related issues were: skyrocketing health care costs, pressures for some form of national health insurance, the clamor for competing recognition by new and more specialized health occupations, competency issues, equal employment challenges, and the Federal Trade Commission's demand that accrediting bodies reform their monopolistic practices.

AGE OF ACCOUNTABILITY

Future historians may well characterize the 1970's as being an era of adversarial activities. A rash of malpractice suits against medical practitioners, many of which ended with substantial damage awards, drove the cost of professional insurance up tenfold. The professions were challenged not only to demonstrate their competence to provide public services, but also to substantiate their exclusionary rights to provide particular services. Consumer groups, governmental agencies and the news media contributed to the challenges.

Government

Perhaps the greatest federal emphasis before and during this period focused on occupations within the health field. Efforts to control rapidly escalating health care costs influenced Congress to mandate that the Department of Health, Education, and Welfare (HEW) seek alternatives to the proliferation of credentialing of newly created health occupations.

The initial study by HEW, Report on Licensure and Related Health Personnel Credentialing, submitted to Congress in 1971, made far-reaching recommendations affecting health manpower. One of these was a proposal for a moratorium on the licensure of additional categories of health occupations to begin immediately and extend for two years. A subsequent report in 1973, Developments in Health Manpower Licensure, recommended a two-year extension of the moratorium, through 1975, to permit further examinations of options and alternatives.

These reports generated considerable additional studies and activities both within and outside the federal establishment. Notable among the latter have been: 1) organizing of the private sector's health certifying organizations, 2) reform legislation within the states, and 3) new efforts to improve certification mechanisms.

A final report, Credentialing Health Manpower, was issued in 1977. This report supported national certification systems as an appropriate alternative to state licensure of health-related occupations not already licensed. It also recommended that a national group be formed in the private sector to provide a forum for such professional organizations, certifying agencies, and federal/state agencies.

The Private Sector

A group of health occupation certifying agencies, educators, and others assembled to study these issues. They concluded that: 1) reform was urgently needed, 2) national voluntary certification was more in the public

interest than licensure, 3) credentialing should be voluntary and external to federal or state control, and 4) a uniform set of national standards for certification should be developed. The National Commission for Health Certifying Agencies was formed in December 1977 at a constitutional convention held in Miami, Florida to establish such standards and to make certification a viable alternative quality-assurance mechanism to licensure.

The Commission has taken upon itself the role of guiding credentialing organizations in the development and setting of standards for certifying the competency of individuals in health occupations. Criteria for recognizing health manpower credentialing organizations, adopted at a December 1978 General Assembly meeting in Atlanta, Georgia, implicitly acknowledged concerns of the 1978 Equal Employment Opportunities Commission Guidelines and the Federal Trade Commission. The criteria are responsive to major portions of the Standards for Education and Psychological Tests and numerous recent Supreme Court and/or Appeals Court decisions impacting upon civil rights and related discriminatory issues.

The standards of the National Commission for Health Certifying Agencies are contained in 41 separate criterion statements. Throughout, there is an emphasis on certifying competence. Criteria require evidence of relevancy, reliability, validity, determination of possible adverse impact upon minorities, and legal and administrative independence of the credentialing organizations from related professional organizations. It is probably safe to say that few if any credentialing organizations among the approximate 100 members of the Commission presently meet all of the criteria for approval and recognition.

There is no "grandfathering" nor waiver of the criteria for recognition. A few of the criteria, however, will not be mandatory until 1981 or 1982.

Reform Legislation Within the States

In the last few years there has been considerable credentialing-related activity within the states. In a few, especially Illinois, California, Virginia, and Minnesota, the reforms and changes have been considerable.

In Minnesota, for example, occupational groups can now be credentialed only if: a) the unregulated practice of the occupation might endanger the health, safety, or welfare of the public; b) specialized skills or training are needed to practice the occupation; or c) the public is not effectively protected by other means.

The Health Manpower Division of the Minnesota Department of Health was established in 1976 to provide staff support for regulating health occupations and for recommending to the state legislature appropriate means of regulating occupations. All health occupational groups (including those credentialed prior to the 1976 changes) desiring to be credentialed in Minnesota must apply to the Health Manpower Division. To be credentialed, an occupational group must first submit detailed information. An advisory council and Division staff rank the application by priority and schedule public meetings to be held by a subcommittee. Recommendations are then made to the full advisory council which, in turn, recommends to the State Board of Health whether to credential or not. Only two types of credentials are used in Minnesota: licensure or registration (which is defined as voluntary certification following national standards, if available, or locally derived interim standards pending nationally

developed ones). Only recommendations for licensure receive legislative consideration. Licensure or registry boards, when established, are housed within the Manpower Division and are staffed with state employees. These major changes in Minnesota are expected to help make credentialing of health-related occupations more responsive to public needs.

Council of State Governments

The Council of State Governments, founded in 1925, conducts studies of issues of particular concern to state governments.

In the last 25 years, it has prepared three studies pertaining to credentialing. The latest, Occupational Licensing: Questions a Legislator Should Ask, has been the most in demand of all the Council's publications during its 55-year existence. This partly reflects the fact that there is less public confidence than ever before in the current system for credentialing occupations. Therefore, a "climate of reform" exists among the legislators.

Occupational Licensing: Questions a Legislator Should Ask is based on the belief that, in all credentialing, the public interest must prevail over professional interests. Among the more important Council recommendations are:

1) that control boards have members from outside the credentialed group,
2) that the board be housed so as to be accountable to government and the public,
3) that the board employees be state employees,
4) that administration of all boards be interrelated into one cohesive system, and
5) that practice acts be revised to identify explicitly what the controlled group does and not merely preclude the use of a title by non-credentialed individuals.

PROJECT CONCEPTS AND THE WORK PLAN

THE PROJECT

At the time the Paraprofessional Mental Health Certification project began, late in 1976, there were about 200 Associate Degree training programs nationally that prepared mental health/human service workers. Most of these programs had developed independently and they were oriented to local needs and the interests of available faculty. Although about 50 had developed with training grant assistance from the Experimental and Special Training Branch, Manpower and Training Division, National Institute of Mental Health, there was no program accrediting or approval mechanism. No national or universal standards existed. However, in a few states (e.g., North Carolina, Connecticut, and California), statewide coordination, approval, and standardization were routine for all postsecondary career/vocational programs located within public institutions.

Project Strategy

In early 1977, a task force was assembled in Atlanta to help identify issues and propose a strategy for the project. (The Appendix lists participants in project conferences.) The group was specifically asked to 1) examine current national issues impinging on mental health/human services manpower development, 2) analyze the implication of those issues for credentialing paraprofessional workers and training programs, and 3) make recommendations for developing project strategy.

The group felt strongly that the objectives of the worker certification project could be met only through the development of a credible system; that empirical data were an essential foundation. With recognition of the limited project staff, resources, and time available, it was recommended that data already collected from mental health/human service settings using functional job analysis techniques be analyzed for possible use to avoid the time and expense of yet another collection effort.

The group also recommended that information about the number of paraprofessionals and their utilization be obtained along with the information about training programs for future comparisons with job analysis data.

CENSUS OF MENTAL HEALTH/HUMAN SERVICES PARAPROFESSIONAL WORKERS

An early activity of this project, in concert with the Program Approval project, was to survey existing training programs to obtain more precise information about their members, characteristics, graduate data, and views of their faculties. This survey, conducted in the early winter of 1976-77, identified a total of 304 training programs which prepared mental health/human service workers at various academic levels; nearly 200 programs were at the Associate of Arts level. It appeared that about 25,000 students were enrolled in these programs at any one time, with nearly half graduating each year. Since the late 1960's when these programs started, there have been more than 60,000 graduates -- a large majority working in the mental health/human service field.

The data obtained from educational and training institutions covered a small portion of the total number of paraprofessional workers, many of whom are trained on the job. (The Paraprofessional Manpower Development Branch of NIMH broadly defines a paraprofessional as "a person who has a baccalaureate degree or less, or who is performing a job that might normally require such a degree.") Additional data were needed to estimate the total number of paraprofessionals nationwide.

The Division of Biometry of NIMH provides manpower statistics for the four core mental health professions -- psychiatry, psychology, social work, and psychiatric nursing. This manpower data also identifies a few other credentialed groups, such as licensed practical nurses, but lumps together "all others." This latter group constitutes about 60 percent of the total personnel staffing mental health facilities and completely subsumes the grouping of workers being addressed in this project.

An earlier attempt was made by NIMH through contract with the University Research Corporation (URC) to identify categories and credentials of personnel employed within community mental health centers. Data on range of duties, qualifications, salary levels, and credentials were collected in seven states. URC found that paraprofessional personnel in various job titles make up about 17 percent of all community mental health staffs. They are the largest single group of direct treatment personnel.

These data do not include large groups of paraprofessionals employed within federal and state institutions nor those involved in community-based programs, other than community mental health centers. An inventory of two geographic areas in the state of Washington -- metropolitan Seattle and a

rural site -- provide some basis for estimating national totals for human service workers.

Extrapolation of these data expanded to national population statistics provides an estimate of the total number of paraprofessionals delivering services on a full-time basis at about 800,000. If part-time and volunteers are also included, the estimate increases more than two-fold to about two million. Thus, reasonable assumption is that there are between 800,000 and two million paraprofessional mental health/human service personnel employed nationwide.

SYMPOSIUM ON COMPETENCE

Another early activity of the project was to explore the many dimensions of the concepts of "competence" and "competency." SREB held a symposium in the spring 1977, to review the state of the art and trends related to competence issues. Educators, researchers, planners, and government administrators involved with competency-based education, manpower, or assessment in mental health services were brought together for sharing of information about their work.

Several themes emerged from this meeting. The two most important were that: 1) competence, not academic degrees, should be the basis for training and hiring mental health workers, and 2) more research is needed in order to develop descriptions and measures of competence. There also was general agreement among the participants that competent performance consists of more than mere knowledge or skills; values and attitudes are also essential

components. The idea that "the whole is more than the sum of the parts" was frequently expressed, as was concern for the need to shift focus away from input and process measures and more toward outcome measures. A summary of the reports and discussions was published and distributed by SREB in Mental Health and Human Services Competency: Issues and Trends.

COMPETENCE/COMPETENCY

Few terms on our language have been subjected to the proliferation of different meanings as have been ascribed to the terms "competence" and "competency." During the last decade it has become fashionable to speak of competency-based training of teachers and health professionals, and to use the same terms to speak of the goals for elementary and secondary education. Competency is sometimes used to describe performance and at other times to describe proficiency. At times the words "competence" and "competency" are used interchangeably.

In the Paraprofessional Worker Certification project, it has been necessary to adopt precise definitions for the terms:

Competence - The overall state of being able to function satisfactorily in a given role or job. This term is used in reference to the global performance of a worker in all aspects of one's work as opposed to proficiency in carrying out a single task or activity of the job.

Competency - A circumscribed skill or characteristic necessary for carrying out a rather discrete portion of a job which can be operationally defined and assessed.

An individual who is competent would be able to demonstrate proficiency in the many individual competencies which make up his/her job.

In speaking of competence, there are at least three levels of competence to be addressed. In credentialing a worker's proficiency for the "right of passage" into an occupational field, a minimum level of competence must be the concern. At some subsequent time, a higher level of proficiency will be the focus. Over an extended period of time and after continued competence has been addressed, some sense of optimal competence may emerge as the ultimate goal for credentialed workers in an occupation.

There is an additional aspect of competence that needs to be considered: "institutional competence." Within mental health/human service settings, there are many things that influence the activities of staff members -- organizational policies, staffing patterns, the constraints of licensure, program and institutional accreditation standards, requirements of third party payers, etc. In many situations, what a particular worker can do competently is never of concern; institutional competence relates to what the workers are permitted or required to do.

SREB's Worker Certification project is concerned with minimum competence for individuals to enter work. However, it is recognized that individuals enter the work force at several different levels. Traditionally, educational attainments or length of related work experience have been used by personnel classification staffs to classify and assign individuals for entry into particular jobs. A specific rationale for levels of generic mental health/human service work and the criteria for it are described in a later section of this report.

The objectives in this project are : 1) to define and describe explicitly the work done by competent mental health/human service workers based upon empirical data collected nationally, and 2) to develop a voluntary credentialing system based on the competencies required to carry out these activities. These work descriptions provide a set of mental health workers activity or competency statements that will be useful to employers in providing services to clients, to personnel workers in recruiting, classifying or evaluating employees, to educators in training individuals for employment, and to third party payers in paying for services provided.

Competency Constructs

There are several approaches that have been used to develop statements of specific worker activities. This project recognized that data derived from functional job analyses would provide the most credible system and would be responsive to Equal Employment Opportunities Commission (EEOC) guidelines, recent court decisions, and criteria established by the National Commission for Health Certifying Agencies. Data collected in several other mental health/human services related projects were synthesized and responded to by a diverse national cross section of workers. Statistical analysis of these evaluation data produced clusters of tasks which collectively comprise the core of mental health/human service work. The analytical techniques of industrial psychology end with these loose listings of grouped tasks. Further organizing of the data files is needed to meet the competency credentialing objectives of the Worker Certification project.

The preliminary work to develop a competency statement format was expanded and refined. The format and specifications finally adopted for describing a competency to be used in the project are:

STATEMENT - A statement of a purposeful activity which is carried out by the worker. Stated in the third-person singular, it contains a specific portrayal of the purpose for which the action is carried out, i.e., "Worker performs...in order to..." A beginning and an end to the performance are explicit or implied in the statements.

INTERPRETATION - A statement of the reasons why the competency is considered to be important in human service work, whether it is essential or desirable, whether it is frequently performed, whether it is a critical activity or those circumstances under which it may become critical, and any conditions that may modify it.

CONTEXT - This is a listing of the conditions under which the activity is to be performed. It includes types of clients and their characteristics; types of settings; time constraints, if any; limit imposed on the worker; other special circumstances; identification of the "level" of the competency.

INDICATORS - This is a listing of the specific behaviors or performance standards the workers are expected to demon-

strate and which an observer would evaluate in order to know whether the worker has satisfactorily performed the competency. They are bits of behavior or quality performance standards that may be carried out in some sequence or concurrently to achieve the overall competency. They are stated in direct third-person singular language (e.g., "Makes eye-contact with interviewee"). Any criterion that is felt to be essential or particularly important is specifically included.

ASSESSMENT - This is the specific method of measurement used to assess the performance. Generally, more than a single method of measurement will be used -- a pencil and paper test of knowledge, a performance test of skills, and a portfolio documentation of related attitudes and behaviors.

STANDARD - This is the specification of the minimum quality level of performance acceptable for certification.

The latter two components, assessment and standards, are the province of experts in testing and assessment. They have not been dealt with in this phase of the Worker Certification project. Similarly, vignettes should serve several purposes: 1) they should amplify and clarify the content and application of each competency statement by naming the client, problem, setting, etc.; 2) they should provide a realistic situation for learning and evaluation;

3) the several vignettes reflecting competency statements will constitute a sampling of situations representing the usual range of clients, problems, settings, levels, etc.

LEVELS

The project's system of levels includes four categories: Entry, Technical, Associate-Professional, and Specialist/Professional. A rationale for levels of work and discussion of the implications of existing classification and manpower systems appear in Staff Roles for Mental Health Personnel: A History and Rationale, an earlier publication of the project.

Although the system contains four levels, the project addressed only two levels in detail, the Technical and the Associate-Professional level. This is a departure from the original objectives of the project. Early planning had proposed the establishment of a credential for the Entry and the Technical levels. The change, shifting upwards to Technical and Associate-Professional, was made to keep the Worker Certification project parallel and compatible with the Program Approval project which addresses standards for Associate Degree and Baccalaureate programs. It was felt that better utilization of the middle groups of Mental Health/Human Service workers would be more enhanced by coupling the levels for training/education standards with the credentialing standards.

Analysis of the project's Job Analysis Survey (JAS) data suggested some factors which bear upon the classification of work levels. More education, more time in position, and greater age appear to relate more to the clusterings

in program administration and management, personnel supervision, technical consultation, fiscal management, program development and evaluation/review. All of the data relating to levels, along with other data commonly used in manpower and personnel functions, were synthesized into a common set of scales and used to classify episodes of work as Technical level, Associate Professional level or both Technical and Associate-Professional. These criteria for judging levels of work are:

Difficulty

Technical level. Competencies requiring theoretical knowledge and proficiency in several intervention techniques and interpersonal skills to work with the common and frequent clients encountered in a mental health program. The problems presented by clients are those of relatively easy-to-learn intervention skills. In an institutional setting, the types of clients may range more widely and the clients' total problems may be complex. However, consultation and supervision for helping deal with the clients' problems are readily available to Technical level personnel. The competencies required are those that the diligent worker could develop through in-service training and a few years of closely supervised work or which could be learned in an Associate Degree program in Mental Health or Human Services.

Associate-Professional level. Competencies requiring theoretical knowledge and proficiency in many intervention techniques, some of which are moderately difficult to master, for relating to the common and frequent as well as to the more uncommon and unusual clients

encountered in a community-based program. The problems presented by clients may be fairly complex. In an institutional setting, the types of clients and client problems include the full range, and the worker is responsible for relatively larger parts of the treatment program. The Associate-Professional level worker may be in charge of a small unit, team or program, or supervise a few Technical level workers. The competencies included at the Associate-Professional level are those the diligent worker could develop through in-service training and several years of supervised and varied experience, or which could be learned in a Baccalaureate program in Mental Health or Human Services.

Discretion

Technical level. Work generally follows established procedures which may be performed under supervision, or supervision and consultation are readily available.

Associate-Professional level. A major portion of the work performed also follows prescribed practices or procedures, but there is more latitude. Supervision is more distant (at another location or is unavailable for up to a day's time). Consultation is available, but it may be distant or available only by telephone, and after some delays.

Risk of Potential Harm

Technical level. Work poorly done generally does not entail potential risk to client's physical, emotional, or economic well-being. Where risk exists, work is performed under close, direct supervision or is prescribed in detail.

Associate-Professional level. Work poorly done may entail mild risk or potential harm to client's well-being. Work may be performed with clients who are grave risks (such as highly suicide-prone clients) but only under direct supervision and with immediate consultation available.

THE WORK PLAN

The work plan decided upon by staff and a small group of consultants was as follows:

1. Examine existing data banks of tasks or activities carried out by mental health/human service workers in a variety of settings to see if they should be used either singly or in some consolidated way to provide a basis for this project to develop behavioral competency statements.
2. With a survey instrument derived from the task data banks of step 1, survey a number (300) of mental health/human service workers in several community and institutional mental health/human service programs throughout the nation to learn whether they carried out those tasks and how frequently they did so. (Job Analysis Survey)
3. Cluster by computer the tasks most frequently performed by mental health/human service workers into major related competency clusters of work activities to serve as the basis for writing a manageable number (40-60) of behavioral competency statements for mental health/human service workers.

4. Write competency statements based on these major clusters through the efforts of staff and task forces of mental health workers.
5. Validate these competency statements by a field survey of 200 mental health workers throughout the nation and obtain their suggestions for appropriate levels of workers to be assigned each competency statement.
6. Decide on appropriate assessment procedures (e.g., pencil and paper tests, performance tests, portfolio assessments) for these competency statements and subcontract the preparation of these assessment mechanisms to companies that specialize in this work.
7. Develop proposed procedures for the entire mental health/human service worker certification process (e.g., application procedures, fees, recertification procedures, etc.) and for an organization to carry out the certification process. (SREB is not an appropriate organization to carry out the certification of individual workers.)

JOB ANALYSIS SURVEY

REVIEW OF DATA BANKS OF MENTAL HEALTH WORKERS TASKS AND ACTIVITIES

A task force was assembled in June 1977 to evaluate existing task data bases and to develop a methodology and format for specifying individual competencies.

The group reviewed 18 taxonomic methods for organizing data about the analysis of the jobs of mental health workers. It was concluded that the interest of the project could best be served by combining five task analysis data banks collected from a variety of mental health/human service settings. These five sets of data and their sources were:

Dallas Community Mental Health Project

Functional job analysis of two community mental health centers in Dallas County, Texas. The principal researcher was Mary Davis Moore with support from the Paraprofessional Branch of NIMH. A report of the project appears in Mental Health and Human Services Competency: Issues and Trends. The job analysis generally followed the procedures developed by Sidney Fine.

Elgin Project

Job analysis of a large state mental health hospital in Illinois. The principal researchers were Stephen W. Wells and Joesph Mehr. The Fund for the Improvement of Post Secondary Education, of the

U.S. Office of Education provided support for the project. A report appears in Mental Health and Human Services Competency: Issues and Trends. The job analysis techniques, while generally consistent with those developed by Fine, were derived by the staff at Elgin State Hospital.

Florida Task Bank

Functional job analysis by the Department of Health and Rehabilitative Services of Florida. Principal investigator was Michael J. Austin. The Social and Rehabilitation Service, of the U.S. Department of Health, Education, and Welfare, provided the support for the project. A brief report of the project appears in Mental Health and Human Services Competency: Issues and Trends. The job analysis technique was a variation of the work diary and time log method and is compatible with the preceding projects. The data are published in The Florida Human Service Task Bank, Volumes I and II, Document No: ED 119573, which is available from Education Resources Information Center (ERIC), P.O. 190, Arlington, Virginia, 22100.

North Carolina Psychiatric Aides

Job analysis of psychiatric aides in the state of North Carolina. The principal investigator, Robert Teare, conducted the project. Job analysis procedures were those developed by Sidney Fine. These unpublished data were furnished to the Worker Certification project by Dr. Teare.

Technomics Task Data

Job analysis of all job functions performed by enlisted ranks within the U.S. Navy. The principal investigator was Robert Parks, Technomics, Inc., under contract with the U.S. Navy. The data contain tasks performed by two levels of psychiatric aides. Job analysis techniques were similar to Sidney Fine's. Data have been published in A Systems Approach to Allied Health Professions, Volume V, Westport, Connecticut 06880.

These collections of mental health task data were merged on the basis of key words within the statements. A Task Force review refined classifications and compared them with other data collections, such as the University Research Corporation data obtained from community mental health centers.

Data Base Development

All five sets of task data banks had utilized the industrial psychology techniques of "functional job analysis" developed by McCormick, Jeameret, and Meehan and adapted to the human services field by Fine and Wiley. There were slightly more than 1400 statements included in these data.

Task statements were sorted to eliminate those inappropriate to mental health human service work. Also, "treating herion addicts with methadone...," was removed as being too unique; that is, it was limited to particular clients in a particular setting. Tasks involving specific therapeutic techniques were culled out (for example, tasks relating to transactional analysis). Behavioral modification tasks, however, were treated as an exception to this

general "technique free" rule, because behavioral modification has become so generalized as a treatment modality, even though it originated from a particular theoretical view. Duplicate and incomplete tasks were also removed. These processes reduced the 1400 tasks to about 400.

An attempt was then made to organize the remaining tasks into a taxonomy of mental health/human service work. The literature was searched for taxonomies of work. Of those reviewed for potential project use, Austin's taxonomy, developed as part of the Florida Task Bank, provided the best framework.

The taxonomic approach, although useful in conceptualizing the field of mental health/human service work, did not reduce the number of separate tasks. Before undergoing review by workers in the field, it seemed essential to reduce the 400 or so separate tasks to about 10 for each of 14 major functions. The goal of selecting 10 representative tasks to describe the range within a function proved to be difficult; for example, there were only three task statements for advocacy, and the management function could not be covered adequately by 10 statements. In the latter case, similar statements were combined and the functional categories of management and data handling were subdivided. In total, 141 statements finally were used. Most of these had been somewhat modified from the original statements, usually to make them broader and more generic or to combine related tasks.

These 141 tasks, distributed across 14 functions (two with sub-categories), were put into a Job Analysis Survey (JAS) format generally following a design previously used by Dr. Teare. Data to be obtained from workers in the field included the frequency with which each of the 141 tasks was performed, the

amount of time spent in an average month doing the function, and the relative availability of supervision. Demographic data about the respondents and data about the institutions in which they worked were also included. The JAS listing of tasks was set up in an open-ended manner to permit the write-in of tasks performed in the field which might have been omitted from the 141 statements.

Data were needed from a substantial number of workers distributed across the country and from all types of mental health service delivery programs. The project expected to compensate for a known bias toward institutional settings in the original task data by selecting half of the workers to be surveyed from community programs and half from institutional programs.

The JAS instrument was piloted at Bryce Hospital in Tuscaloosa, Alabama. This try-out disclosed a problem with the terminology used in task statements pertaining to personal care, and instructions were revised to clarify the descriptions of the task groupings. (The entire JAS appears in the Appendix.)

Survey data were solicited through coordinators located in Alabama, California, Colorado, Florida, Maine, Ohio, and Pennsylvania. A sub-sample drawn from a national organization headquartered in New York was contacted by mail. Respondents were offered a nominal payment of $5.00 as an inducement for completion of the JAS instrument.

Coordinators were instructed to submit responses only from individuals who fit NIMH's definition of paraprofessional. Thus, individuals with formal education which included a graduate degree were to be excluded from

the response group as were other specifically credentialed groups, such as licensed practical nurse.

Data Analysis

A total of 211 usable responses were received within the deadline set for returns, somewhat below the original goal of 300 responses. Initial processing involved removing the respondent's name and address, the list of "write-in" tasks, the name of last educational institution attended, and responses to the question, "Just what does your agency/institution do?"

Analysis of the write-in tasks provided no additional information warranting inclusion. Additions proposed by the respondents were semantic differences or fragments of more generic statements, unique to a particular setting, such as "interpreting for a deaf client."

The respondents included individuals with 56 different job titles. Those of mental health worker, psychiatric aide, and program director/assistant were the most frequent and included more than half of all respondents. Many functional job titles appeared, such as family worker, peer counselor, or alcohol (drug) services workers. The entire range of mental health settings outside of general hospitals or physical health agencies was represented among the respondents.

DEVELOPMENT OF CLUSTERS OF TASKS AND COMPETENCY STATEMENTS

After the data from the Job Analysis Survey had been obtained, the next step was to analyze it to identify major clusters of tasks and activities that could be the basis for the development of a manageable number of competency statements since it was not feasible to develop a competency system based on several hundred separate tasks. Thus, data from the Job Analysis Survey were coded and key-punched for computer analysis at the University of Alabama. The computer program used was the Ward and Hook program for hierarchial grouping. This procedure, using the frequency data response to each task, groups the tasks that are related.

Twenty-three "clusters" of work and their intercorrelations were identified on this first part of the analysis. The original taxonomy of functions utilized to organize the task data included 14 functions. Cluster analysis provided a finer discrimination of functions than had been used initially. Logical study of the grouped tasks led to the assignment of the following labels to these clusters:

1. Active Linkage (doing it for the client)
2. Passive Linkage (helping the client get it done)
3. Client Advocacy
4. Continuous Client Assignment and Disposition
5. Program Development/Activation
6. Client/Collateral Follow-up
7. Counseling - Anxiety Reduction
8. Carrying Out Structured Procedures

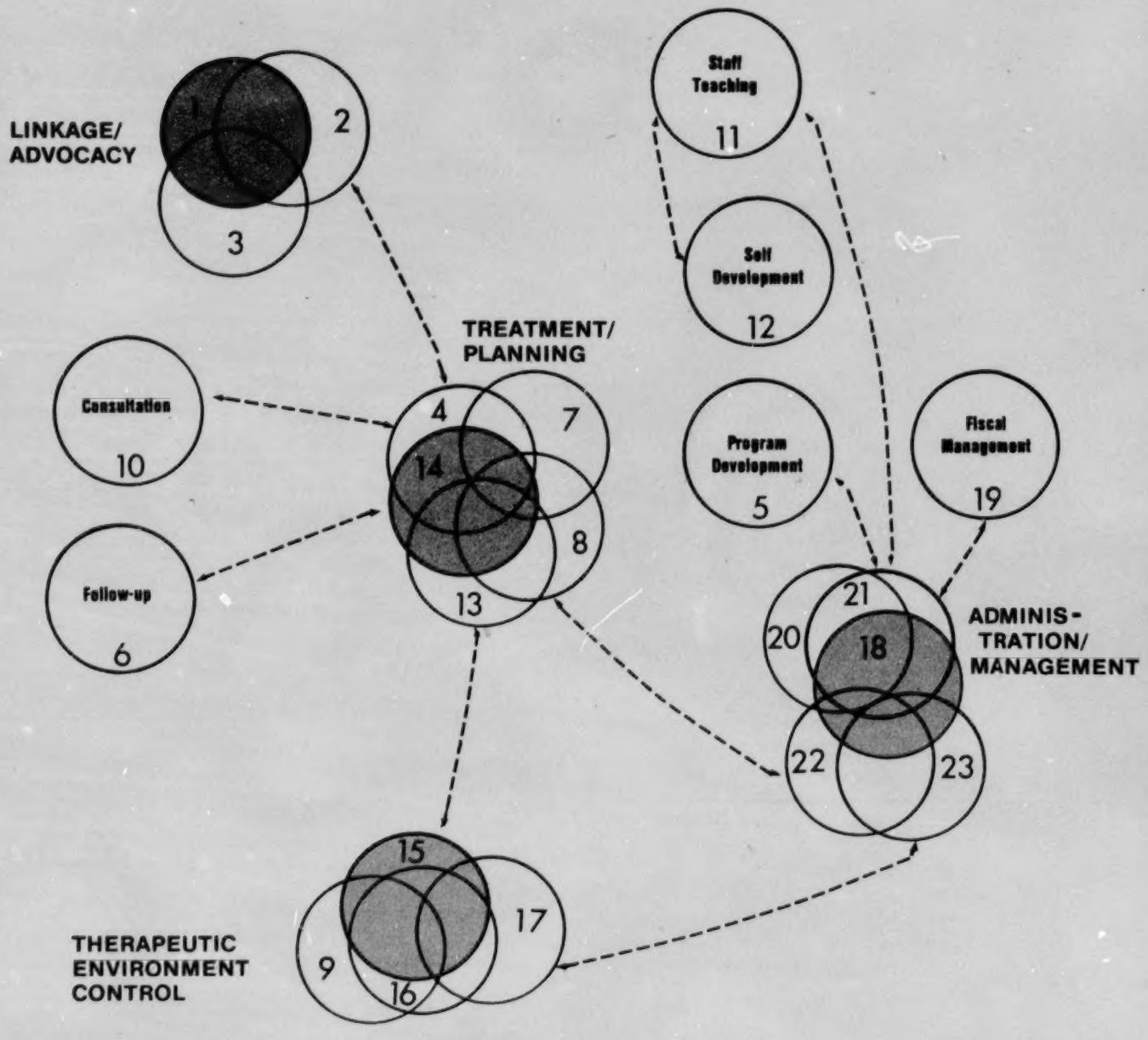
9. Teaching Clients (self-help, living skills)
10. Giving/Receiving Consultation
11. Planning and Carrying Out Staff Training and Development
12. Self-Development (formal, informal)
13. Reinforcing Client Behavior (associated case management)
14. Developing/Coordinating/Documenting Treatment Plans
15. Structuring-Observing Microenvironment (therapeutic)
16. Maintaining Behavior Stability (passive)
17. Behavior Restriction/Control (active)
18. Managing Policy-related Data/Communicating Policy
19. Managing Fiscal Data
20. Supervising Staff
21. Carrying Out Staffing (recruiting, evaluating, selecting)
22. Inventory Control
23. Managing Physical Environment (non-therapeutic)

A graphic plotting of these clusters by intercorrelation, that is, proportional overlaps, appear in Figure 1. A Pearson r value of .60 was used as an arbitrary cut-off. The data indicated that mental health/human service work centers around four major areas -- linkage/advocacy, treatment/planning, administrative/management, and therapeutic environment control.

Six other semi-independent clusters had intercorrelational values of less than r = .60 -- "follow-up," "consultation," "program development," "staff teaching," "self development," and "fiscal management." However, each is shown connecting with the cluster with which it has the greatest intercorrelationship (higher r value).

Additional processing of the data provided further analysis. Perhaps the most significant findings from the ancillary data relate to levels of work and differences between community mental health and institutional work. The data provide no specific rationale for levels of work. The analysis suggests that work is a continuum. However, individuals with greater work experience and, thus, generally older and those with more formal education are more often involved in program development and management-related work.

FIGURE 1
PLOTTING OF MENTAL HEALTH/HUMAN SERVICE TASK CLUSTERS



1. Active Linkage (doing it for the client)
2. Passive Linkage (helping the client get it done)
3. Client Advocacy
4. Continuous Client Assignment and Disposition
5. Program Development/Activation
6. Client/Collateral Follow-up
7. Counseling — Anxiety Reduction
8. Carrying Out Structured Procedures
9. Teaching Clients (self-help, living skills)
10. Giving/Receiving Consultation
11. Planning and Carrying Out Staff Training and Development
12. Self-Development (formal, informal)
13. Reinforcing/Shaping Client Behavior (associated case management)
14. Developing/Coordinating/Documenting Treatment Plan
15. Structuring-Observing Micro-environment (therapeutic)
16. Maintaining Behavior Stability (passive)
17. Behavior Restriction/Control (active)
18. Managing Policy-related Data/Communicating Policy
19. Managing Fiscal Data
20. Supervising Staff
21. Carrying Out Staffing (recruiting, evaluating, selecting)
22. Inventory Control
23. Managing Physical Environment (non-therapeutic)

Although addressed only indirectly by the methodology, community mental health work seems to differ from mental hospital work primarily in the personal care area. Tasks relating to therapeutic environment control appear only in relation to residential treatment. Community mental health services seldom involve the same degree of continuous and/or nurturant care.

WRITING COMPETENCY STATEMENTS

Following an agreed-upon format, competency statements were written around the clusters of tasks derived from the functional job analysis survey. Task forces were assembled to review and revise the statements on three occasions between January and September 1978.

Competency Statement Format

Preliminary work had been done by a task group toward developing a format for the competency statements. The group felt that competency statements must include:

Process: An active statement that describes an observable and measurable performance which has both a beginning and an end;

Outcome: An explicit or implicit purpose behind the performance that is intentional;

Context: The delimiting of the environment and situational factors, such as age, sex, ethnic membership, etc.;

Quality: The minimum to optimum level of acceptable performance.

The writing of competency statements was time-consuming -- there were no specific guidelines to follow; no prescriptions, rules or lists of procedural steps existed; the process was that of trial and error.

The following steps describe the procedures utilized in deriving each competency statement:

1) Some organizing medium was sought among the tasks within a single cluster, e.g., a functional commonality that was common throughout and which tied the tasks together. For example, in the first cluster, "linkage" seemed too broad since clusters two and three also are linkage-related. Doing it for the client rather than teaching, guiding, or assisting the client to do it for him/herself seemed to be a common element in all six tasks within the cluster.

2) With the content of the clustered tasks in mind, a broad generic statement was composed which fulfilled the specifications for competency statements. (For example, "Worker refers client in order to link client with another service.") The statements needed to describe an episode of work which was large enough to be generic across clients, problems and settings, yet small enough to be meaningful in content for teaching, measurement, etc.

The statement also needed to embrace all or as many as possible of the tasks included in the cluster, identify modifiers and/or recipients of the action, include appropriate purpose, and contain at least an implicit beginning and end.

3) The statement was interpreted or amplified. Other information such as how commonplace, how frequent, and where the competency is to be performed--

inter- or intra-agency, how important or critical, etc., were added under Interpretation to clarify the intent or purpose.

4) The competency was delimited. That is, the type of client and problems involved, the type and amount of service and the setting were identified and included, along with reference to the appropriate parts of the characteristics scales which describe and define levels of work. These were added under the Context.

5) A listing of indicators was added. These specific behaviors or standards of performance which are part of or go together to make up the competency. Most of the indicators are stated in behavioral terms which are observable. No specific ordering or sequencing of these indicators was attempted.

Two additional steps, measurement procedures and minimum performance standards, need to be added to each competency statement. These will be addressed in a subsequent phase of the project, along with preparing a series of vignettes or case examples for each of the statements.

The terms "worker" and "client" were standardized throughout the collection of competency statements and an attempt was made to make these as uniform as possible.

The writing of the competency statements involved many selective judgments. Writers initially synthesized explicit task data and proposed language which conceptualized the content into generic statements. The number of possible competency statements was extremely large; however, it was found that the competency descriptions, although varied between writers, generally contained about the same material. There was reasonable agreement among the writers.

Each competency statement was initially prepared by a single person; about half originated with project staff. Each statement was reviewed by one or more individuals and modified as deemed necessary. Task forces were used in three separate occasions for greater consensus and expansion of the items contained within the statements. Every statement was subjected to both individual and collective judgments of at least a dozen workers, supervisors, and educators before being sent to the field for even broader review and evaluation.

A record of the use of both original tasks and the derived clusters was maintained throughout the writing process to assure that the entire range of tasks had been covered. Final tabulation indicated that each of the 141 original statements had been used in from two to 12 competency statements. In a somewhat similar way, two to 13 competency statements covered all or part of each of the 23 clusters of tasks.

Although there is some redundancy in the statements, it is felt that the overlaps should help to reduce the subsequent measurement error.

Competency statements have been prepared for only the Technical and Associate-Professional levels of paraprofessional workers. These levels approximate two and four years of efficient and progressive learning time, respectively.

The set of 40 competency statements appear in Appendix 2.

COMPETENCY STATEMENTS RELATED TO COMMUNICATION

During the writing of competency statements it became increasingly obvious that the theme of "communications" would be a problem area. Communications of one type or another seemed to run through nearly all of the competency statements. Analysis of the problem suggested that interpersonal communication was a very important element of all client service competencies and that it was a reasonably discrete activity. Statement Number 25 was prepared around the interpersonal communication theme and put into a therapeutic context.

Other communication activities appeared to center around recorded information. Similarly, although written communication was an identifiable part of many competencies, the project decided to deal with it separately. As a result, competency statement Number 40 was developed. In part these decisions to separate communication skills were made in order to be able to provide specific feedback to workers being tested as to their performance on these basic skills. Information about specific communication problems will be essential to individuals to permit them to undertake additional training to remedy these deficiencies which underlie so many of the other competencies. This may be especially helpful to persons whose educational opportunities and attainments have been limited and could make poor showing on the competencies due to weaknesses in communication ability rather than because of lack of proficiency in the competency.

These two communication competencies were developed through Delphi procedures. They will be included in the assessment process, but scored only for reporting purposes. Standards for reporting overall performance will be developed through relationships between these two statements and the other 38 which have strong communication components. Candidates for certification then can be provided information about their communication competencies apart from the weighted competencies included within the minimum standards for credentialing.

Where an individual does not meet credentialing standards due to communication deficiencies apart from content and context, he or she then will be able to concentrate on remedial education efforts in communciation skills.

FIELD VERIFICATION OF COMPETENCY STATEMENTS

Competency statements as described earlier are abstract statements which do not portray work with sufficient clarity to permit measurement of the performance being described. Additional information is needed to design a measurement or assessment protocol to weight individual competency statements proportional to their relative importance and to ultimately establish performance standards at appropriate levels.

REQUIREMENTS

For verification one needs to know:

that the work described in each competency statement is generally performed by mental health/human service workers in a wide variety of work settings and geographical locations;

the frequency with which that work is performed;

the degree of importance to the client for mental health/human service workers to perform the work;

the degree of potential economical, sociological, psychological, or physical risk to the recipient of service if the work is poorly performed.

A total of 40 competency statements had been prepared which covered the entire range of mental health/human service work at the Technical and Associate-Professional level. Based upon the level criteria described earlier, each statement had been assigned to either the Technical or

Associate-Professional level or both. There were eight statements at the Technical level, seven at the Associate-Professional level, and twenty-five at both the Technical and Associate-Professional levels.

METHOD

An evaluation questionnaire was prepared that addressed five questions: whether the work of each activity statement was done by mental health workers, the frequency with which it was done, the importance of the work, the risk of a job poorly done, and the appropriate level of worker to do the work. The questionnaire packet was a thick document with a separate answer sheet, a cover letter, a project summary, and the 40 competency statements. The competency statements, slightly revised from the form in which they were mailed out, appear in Appendix 1.

Field evaluation data consisted of responses to the following five specific questions for each competency statement. Replies were to be focused on the work done by mental health/human service workers within each respondent's work setting.

1) Is the competency applicable in your agency or institution?
   ( ) Done
   ( ) Not Done

2) How frequently is the competency performed in your agency or institution?
   ( ) Rarely
   ( ) Occasionally
   ( ) As often as not
   ( ) Very often
   ( ) Always

3) How important to the client is it for this competency to be done?
   ( ) Unimportant
   ( ) Of some importance
   ( ) Desirable
   ( ) Important
   ( ) Essential

4) What is the potential risk of harm to clients' physical, emotional, or economic well-being if the work is poorly done?

( ) No identifiable risks ( ) Considerable risk
( ) Slight risk ( ) Grave risk
( ) Moderate risk

5) What is the lowest level of worker who usually performs the work described in the competency statement?

( ) Entry
( ) Technical
( ) Associate-Professional
( ) Professional/Specialist

To encourage responses, since the amount of time (up to two and a half hours) was now considerably greater, each respondent was paid $10.00.

Because of the large amount of time required for each respondent, a mail-out approach seemed to hold little potential. As an alternative, on-site evaluation meetings with small groups were arranged with the National Organization of Human Services at Denver, the National Association of Human Service Technologies at Los Angeles, the Orange County Community Mental Health Center at Santa Ana, the Community Congress at San Diego, the Alabama Organization of Mental Health Technologists at Tuscaloosa, the Maryland Organization of Mental Health Associates at Baltimore, and the Northeast Florida State Hospital at MacClenny, Florida.

A total of 75 evaluations was collected on-site in this manner. Each respondent was requested to solicit an additional evaluation from his/her supervisor and/or colleagues, but this proved to be too difficult.

The procedures used to obtain evaluations from workers and supervisors were modified for obtaining input from educators and faculty. As an alternative, 65 evaluation packets were mailed to faculty members around the country.

Reminder letters and subsequent visits to mental health centers and hospitals raised the final number of respondents to 200.

RESPONSE ANALYSIS

The respondents to the competency statement verification survey included workers with 56 different job titles. The larger groups, comprising nearly half of all respondents, were Mental Health Technician/Technologists, Psychiatric Technicians, Rehabilitation Technician/Specialists, Educators, and Team/Unit Administrator/Supervisors. Only a few respondents to the Competency Statement Evaluation had previously been involved with the Job Analysis Survey, however, the same tendency for the use of functional job titles also existed with this group.

The average age of this validation groups was nearly the same as that of the JAS group. Males made up a slightly higher proportion of the validation group. There were fewer minorities, especially blacks, in the latter group. On the whole, the latter group had slightly greater formal education, possibly because responses were also solicited from a limited number of supervisors and educators, sub-groups generally were dominated by individuals possessing higher academic credentials. See Table 1.

Table 2 contains a breakdown by state for responses to both the JAS and the competency statement verification.

With each of the 40 competency statements to be evaluated on the five questions, each respondent provided up to 1900 pieces of information. The tallies of these responses appear in Tables 3 to 6.

Respondents were asked in question 7 to react to the level of placement which had previously been assigned to the competency statements. Respondents

TABLE 1

SELECTED DEMOGRAPHIC CHARACTERISTICS AMONG RESPONDENT POPULATIONS ON JOB ANALYSIS SURVEY AND COMPETENCY VERIFICATION

Characteristic	Job Analysis Survey Population	Competency Verification Population
Mean Age	35.9 Years	34.3 Years
Sex	68 Male 147 Female	72 Male 129 Female
Ethnic Membership		
White	72.6 %	83.5 %
Negro	17.2 %	9.9 %
American Indian	.9 %	1.8 %
Asian American	.9 %	0 %
Latin American	5.6 %	1.8 %
Other or not reported	2.8 %	3.0 %
Mean Educational Level	over 14 Years *	15.5 Years
Mean Time in Present Position	7.8 Years	7.2 Years

*The survey did not ask for a top number of years of education.

TABLE 2

JOB ANALYSIS SURVEY AND COMPETENCY STATEMENT VERIFICATION RESPONSES BY STATE

State	Job Analysis Survey	Competency Statement Verification
Alabama	23	21
Alaska	0	1
California	58	46
Colorado	23	15
Connecticut	1	1
Florida	31	49
Georgia	0	2
Hawaii	1	0
Illinois	6	0
Indiana	0	2
Iowa	1	0
Kentucky	4	1
Maine	21	0
Maryland	0	19
Massachusetts	0	4
Minnesota	1	4
New Jersey	2	2
New York	0	1
North Carolina	0	2
Ohio	19	17
Pennsylvania	19	1
South Carolina	0	1
Texas	0	5
Virginia	0	4
Washington	4	3
Wisconsin	1	0
	N = 215	N = 201

TABLE 3

RESPONSE FREQUENCIES FOR COMPETENCY STATEMENT VERIFICATION:

APPLICABILITY

Statement #	Done	Not Done	Statement #	Done	Not Done
01 (T)*	120	84	20 (T-AP)	112	92
02 (T)	199	5	21 (T-AP)	198	6
03 (T)	191	13	22 (T-AP)	195	9
04 (AP)	169	35	23 (AP)	152	52
05 (AP)	191	13	24 (T-AP)	181	23
06 (T)	199	5	25 (T-AP)	195	9
07 (T-AP)	187	17	26 (T-AP)	204	
08 (T-AP)	184	20	27 (T-AP)	187	17
09 (T-AP)	170	34	28 (T-AP)	175	29
10 (T-AP)	180	24	29 (AP)	157	47
11 (T)	171	33	30 (T-AP)	110	94
12 (T)	135	69	31 (T-AP)	120	80
13 (T-AP)	167	37	32 (T-AP)	179	25
14 (AP)	142	62	33 (T-AP)	162	42
15 (T-AP)	122	82	34 (T)	149	55
16 (T-AP)	192	12	35 (AP)	161	43
17 (T-AP)	178	26	36 (AP)	149	55
18 (T)	133	71	37 (AP)	131	73
19 (T-AP)	173	31	39 (T-AP)	134	70

* T = Technical
AP = Associate Professional
T-AP = Technical & Associate Professional

TABLE 4

RESPONSE FREQUENCIES FOR COMPETENCY STATEMENT VERIFICATION:

OCCURRENCE

Statement Number	Scale Values 1	2	3	4	5	Statement Number	Scale Values 1	2	3	4	5
01	5	19	7	36	53	20	4	33	13	32	30
02	1	26	17	93	62	21	3	6	16	89	84
03	3	27	24	81	56	22	0	14	19	66	96
04	6	54	22	59	28	23	16	37	32	49	18
05	1	18	25	70	57	24	3	27	30	85	36
06	1	26	25	84	63	25	0	16	20	86	73
07	1	26	14	51	95	26	4	30	41	84	45
08	2	27	25	74	56	27	0	30	34	99	24
09	6	29	32	74	29	28	5	36	31	[illegible]	29
10	4	13	16	67	80	29	11	26	21	65	34
11	3	16	17	55	80	30	8	22	18	42	20
12	7	21	7	50	50	31	10	36	24	36	18
13	3	14	18	38	94	32	27	42	13	54	43
14	30	63	19	22	8	33	9	38	44	53	17
15	5	25	16	49	17	34	9	29	34	57	20
16	2	27	13	83	67	35	6	31	16	59	49
17	5	51	47	51	24	36	20	43	30	33	23
18	10	21	21	40	41	37	25	48	19	24	15
19	5	22	21	73	52	38	19	45	13	35	21

1 = Rarely
2 = Occasionally
3 = As often as not
4 = Very Often
5 = Always

TABLE 5

RESPONSE FREQUENCIES FOR COMPETENCY STATEMENT VERIFICATION:

IMPORTANCE

Statement Number	Scale Values 1	2	3	4	5	Statement Number	Scale Values 1	2	3	4	5
01	4	10	8	47	54	20	1	16	19	41	35
02	1	8	23	77	89	21	1	16	14	70	111
03	1	6	19	90	75	22	2	7	11	64	111
04	4	12	30	61	62	23	4	4	36	75	34
05	2	4	18	68	98	24	1	8	22	92	58
06	1	1	18	83	95	25	2	3	19	79	92
07	2	3	17	55	110	26	1	3	33	84	83
08	2	7	28	101	46	27	2	9	24	114	38
09	0	6	24	86	54	28	1	13	43	89	29
10	2	5	13	58	102	29	3	11	29	63	51
11	1	7	14	45	104	30	1	4	19	47	39
12	2	8	4	29	92	31	0	8	25	56	35
13	3	7	11	58	88	32	1	6	8	37	127
14	2	19	40	66	15	33	2	9	50	66	34
15	0	2	28	68	24	34	5	21	32	62	29
16	1	4	19	82	85	35	1	11	20	71	58
17	1	9	36	87	45	36	0	16	27	60	45
18	1	6	5	45	75	37	1	18	26	52	34
19	1	6	22	101	43	38	0	15	34	57	27

1 = Unimportant
2 = Of some importance
3 = Desirable
4 = Important
5 = Essential

17

TABLE 6

RESPONSE FREQUENCIES FOR COMPETENCY STATEMENT VERIFICATION:

RISK TO CLIENT

Statement Number	Scale Values 1	2	3	4	5	Statement Number	Scale Values 1	2	3	4	5
01	26	45	21	27	0	20	34	38	20	14	5
02	23	43	68	57	8	21	22	43	60	56	17
03	30	47	64	44	6	22	35	35	56	44	25
04	48	38	37	36	9	23	62	42	29	12	6
05	31	45	58	46	10	24	61	37	45	29	9
06	31	51	69	39	9	25	61	38	51	36	9
07	36	47	56	35	13	26	93	40	40	26	4
08	21	68	68	19	8	27	43	54	55	30	5
09	30	40	54	39	7	28	42	59	48	23	3
10	20	38	48	57	17	29	66	41	29	12	9
11	20	43	30	47	31	30	15	30	39	23	3
12	5	12	17	41	60	31	11	40	48	19	5
13	32	30	41	39	25	32	7	9	28	50	85
14	58	41	37	6	0	33	68	46	25	14	7
15	8	31	36	36	10	34	92	37	16	3	1
16	47	35	56	43	12	35	51	42	38	21	9
17	29	46	57	37	9	36	49	35	34	26	5
18	10	13	21	37	52	37	57	39	30	4	1
19	21	36	59	47	10	38	59	41	22	9	2

1 = No identifiable risk
2 = Slight risk
3 = Moderate risk
4 = Considerable risk
5 = Grave risk

TABLE 7

RESPONSE FREQUENCIES FOR COMPETENCY STATEMENT VERIFICATION:

LEVEL OF WORK

Statement Number	Scale Values 1	2	3	4	Statement Number	Scale Values 1	2	3	4
01	33	57	24	3	20	15	42	41	14
02	16	138	43	3	21	35	115	42	5
03	18	114	52	7	22	28	111	51	5
04	10	31	95	31	23	8	19	99	26
05	20	106	58	6	24	18	91	63	10
06	43	117	35	4	25	48	104	37	6
07	15	94	69	8	26	54	108	33	8
08	30	103	45	5	27	17	101	61	8
09	13	84	65	8	28	12	97	55	11
10	14	96	63	7	29	15	39	75	28
11	41	105	24	1	30	15	59	32	4
12	17	80	27	11	31	9	69	38	8
13	25	97	42	3	32	45	104	29	1
14	6	33	71	32	33	14	70	70	6
15	9	55	47	11	34	61	61	22	5
16	15	113	55	10	35	9	31	96	24
17	14	99	60	6	36	8	25	92	24
18	22	79	26	7	37	9	17	74	30
19	10	97	57	9	38	2	37	63	31

1 = Entry
2 = Technical
3 = Associate-Professional
4 = Professional/Specialist

Note: Original assigned level is underlined.

19

TABLE 8

PERCENTAGES AND MEAN RATINGS
ASSIGNED TO INDIVIDUAL COMPETENCY STATEMENTS

Number/Level	Title	% Done	$\bar{x}$ Freq.	$\bar{x}$ Imp.	$\bar{x}$ Risk	$\bar{x}$ Lev
01 (T)	Eligibility Determination	59	3.94	4.22	2.39	1.93
02 (T)	Behavioral Techniques	98	3.95	4.22	2.92	2.18
03 (T)	Preparation for Transition	94	3.84	4.22	2.73	2.25
04 (AP)	Plans Service Delivery Program	83	3.29	3.98	2.51	2.85
05 (AP)	Explains Service Plan	94	3.54	4.32	2.77	2.25
06 (T)	Personal Living Skills	98	3.91	4.34	2.72	2.00
07 (T-AP)	Data Handling/Case Planning	92	4.14	4.43	2.69	2.36
08 (T-AP)	Conducts Activity Program	90	3.84	3.99	2.45	2.13
09 (T-AP)	Service Referral	83	3.54	4.11	2.72	2.40
10 (T-AP)	Problem Identification - Linkage	88	4.14	4.41	3.07	2.35
11 (T)	Nutures Client	84	4.13	4.43	3.15	1.91
12 (T)	Monitors Medication	66	3.85	4.49	4.03	2.24
13 (T-AP)	Transfer Responsibility	82	4.23	4.32	2.97	2.14
14 (AP)	Advocates for New Program	70	2.40	3.51	1.94	2.91
15 (T-AP)	Monitoring Client Placement	60	3.15	3.93	3.05	2.49
16 (T-AP)	Team Review	94	3.97	4.27	2.69	2.32
17 (T-AP)	Client Advocacy	87	3.21	3.93	2.72	2.34
18 (T)	Monitors Medical Treatment	65	3.61	4.38	3.81	2.15
19 (T-AP)	Group Therapy	85	3.84	4.03	2.94	2.38
20 (T-AP)	Fiscal Management	55	3.46	3.83	2.24	2.48
21 (T-AP)	Facilitating Changes in Client Behavior	97	4.24	4.45	3.02	2.08
22 (T-AP)	Observing, Recording and Interpreting Behavior	96	4.30	4.41	2.94	2.17
23 (AP)	Staff Development/Training	75	3.11	3.88	2.05	2.94
24 (T-AP)	Consultation	89	3.66	4.09	2.38	2.37
25 (T-AP)	Interactive Communication	96	4.11	4.31	2.46	2.01
26 (T-AP)	Self Development	100	3.67	4.20	2.04	1.97

7	(T-AP)	Leading/Facilitating Group Problem Solving and Decision Making	92	3.28	3.95	2.47	2.32
8	(T-AP)	Facilitating Learning Experience in a Group Setting	86	3.49	3.75	2.35	2.37
9	(AP)	Manage and Communicate Policy-related Data	77	3.54	3.94	2.09	2.74
0	(T-AP)	Home Visitation and Follow-up	54	3.40	4.08	2.72	2.23
1	(T-AP)	Vocational Training and Job Placement	61	3.13	3.95	2.71	2.36
2	(T-AP)	Violent and Destructive Behavior Control	88	3.25	4.58	4.10	1.92
3	(T-AP)	Liaison	79	3.17	3.73	2.01	2.40
4	(T)	Logistics -- Supplies and Equipment	73	3.34	3.60	1.55	1.81
5	(AP)	Staff Supervision	79	3.71	4.08	2.35	2.83
6	(AP)	Personnel Functions: Recruitment/Selection	73	2.97	3.88	2.48	2.89
7	(AP)	Personnel Functions: Employee Relations	64	2.66	3.76	1.88	2.94
8	(T-AP)	Research/Evaluation	66	2.93	3.69	1.89	2.90
9	(T-AP)	Providing Information in Written Form					
0	(T-AP)	Obtaining Information from Recorded Materials					

Frequency Scales: 1 = Rarely
2 = Occasionally
3 = As often as not
4 = Very often
5 = Always

Levels of Work: 1 = Entry
2 = Technical
3 = Associate/ Professional
4 = Professional/ Specialist

Importance Scales: 1 = Unimportant
2 = Of some importance
3 = Desirable
4 = Important
5 = Essential

Risk Scales: 1 = No identifiable risk
2 = Slight risk
3 = Moderate risk
4 = Considerable risk
5 = Grave risk

had the same degree of freedom in response as they would have had without an assigned placement. However, the assigned placement created some degree of bias toward this level. In Table 7, the originally assigned placement level is indicated by underlining.

FINDINGS

No extensive statistical analysis of the resulting data has been performed. Responses to question number one, "done" -- "not done," have been converted to percentages and appear under the % column of Table 8.

The activity "Self-Development" is universally carried out by mental health workers. Other activities very frequently done, in order of decreasing frequency, are: "Behavioral Techniques," "Personal Living Skills," and "Facilitating Change in Client's Behavior." The activity least done by mental health/human service workers is "Home Visitation and Follow-Up." Others with almost as low a "done" response are "Fiscal Management" and "Eligibility Determination." All of these, however, are identified as "done" by more than half of the respondents.

Six activities were reported to be done at a frequently labeled "very often." All are direct service functions: "Observe, Record, and Interpret Client Behavior," "Facilitate Changes in Client Behavior," "Data Handling/Case Planning," "Problem Identification and Linkage," "Nurtures Client," and "Interpersonal Communication." Surprisingly, no activity statement was reported as being done only occasionally. Only one fell below the mid-point of the scale: "Advocates for New Programs."

The competency reported to be the most important to clients was "Violent or Destructive Behavior Control." "Monitors Medication" and "Facilitates Change in Client Behavior" were reported at nearly the same point. "Advocacy for New Programs," "Logistics -- Supplies and Equipment," and "Research/Evaluation" were reported least important to the client -- but none was scaled below the midpoint of the scale of importance.

Only two activity statements were scaled above the level of considerable risk: "Violent or Destructive Behavior Control" and "Monitors Medication." Four statements were rated with low risk: "Advocates for New Programs," "Research/Education," "Personnel Functions: Employee Relations," and "Logistics -- Supplies and Equipment" was lowest.

Scaling levels, as mentioned earlier, were potentially biased. With a four-point scale for response to the question of the "lowest level of mental health/human service worker which usually performs the competency," ratings reflect a central tendency around the Technical level. Overall, the averages for the levels range from a low of 1.81 (for "Logistics -- Supplies and Equipment") to a high of 2.94; a total spread of 1.13 or just slightly greater than the breadth of a single level of work. Obviously, in the views of the respondents, the collection of statements are quite homogenous with respect to levels and primarily bracket the Technical to Associate-Professional portions of the levels of work.

Respondents were asked for general comments on the competency statement evaluation. Less than half made comments, and those comments were perfunctory, such as "complete," "realistic," and "appropriate." A few persons objected to the

use of words such as "diagnosis" or posed questions about the future examination procedure.

Several substantive issues were raised that should be considered during the development of standards for both certification of individuals and approval of training programs -- concern that the competency statements as a whole reflect skills that can be trained in specific technical training programs and encompass much general education and life skills; concern that the distinctions between levels were not sharp enough, although other persons felt the criteria were clear enough; concern that local agency policies restricted workers from performing certain competencies. There were no consistent comments nor recurring themes that militate against this conceptualization of worker activities for mental health/human service work. A few semantic changes were made to some of the statements -- none of which were substantive. The statements as they appear in Appendix 1 are the revised statements.

Weighting

Data included in Tables 3 to 7 provide the basis for assigning weights to each of the competency statements. Variable weighting, rather than unit weighting, is suggested by the categories of importance and risk. Only human judgment, perhaps with a reasonable consensus, can provide a credible system for use in weighting these competency statements and credentialing those individuals who attain a satisfactory quality of performance.

Vignettes

As part of the competency statement verification process, respondents were requested to provide two or more typical case situations or vignettes.

Sample vignettes were provided along with an answer sheet which provided sufficient format to prompt the respondents to provide their own vignettes: most respondents provided at least one. This collection of case situations remains to be cataloged, evaluated, and made a part of the context for each competency statement.

Responses were obtained from 22 states. The major concentration in order of the largest grouping. came from Florida, California, Alabama, Maryland, Ohio, and Colorado. A total of just over 200 usable responses were obtained by the final cut-off date.

DEVELOPMENT OF AN ASSESSMENT METHODOLOGY

TESTING PROCEDURES

It is envisioned that assessment of candidates or candidates' proficiency in carrying out the competencies will be done by a combination of testing procedures. Testing for knowledge is by far the most highly developed and most frequent means for occupational entry. The machine-scorable multiple-choice format has great utility along with highly accepted reliability and validity, although it is being questioned more and more.

Performance-testing is less well-developed, and compared to knowledge testing is quite costly. Applied research efforts with video simulation hold considerable promise for cost containment along with the desired standardization that is essential in order to obtain acceptable levels of reliability and validity.

A third assessment procedure, the portfolio approach, has been used in assessing experience for award of academic credit, for personnel classification, and for credentialing of a few human service occupations, such as child development associates. This procedure is conducive to assessing the less well-defined areas of motivation, attitudes, values, and work-adaptive skills.

Ideally, each competency statement will be measured by each assessment methodology. Such redundancy would be desirable for reducing total measurement error. Practically, though, some compromise must be reached. The reduction of error must be balanced against the practicalities of cost, time and convenience to the candidates.

Each methodology of measurement has its strengths and weaknesses. Determination of the method to be used for each particular competency statement is left for the subsequent assessment phase of the project.

CERTIFICATION SCHEMA

The overall concept for certification of paraprofessional mental health/human service workers on the basis of performance was described in a project paper entitled Proposed Certification Process for Mental Health/Human Service Workers. This paper was distributed to about 1300 individual organizations and agencies nationwide which had an interest in the project. Responses and critique of the ideas presented were solicited.

Although the response rate was not particularly strong, about 100 returns were received. Most comments were generally favorable. However, many questions were also raised. For example, Who would do the testing and the certifying? Would retesting be required? Who would pay for it and how much would it cost?

A task force was assembled to assist the review of comments and to recommend future activities. It was the general consensus of group that, following the development of the competency statements, approaches to measurement/assessment and mobilization of an organization to do the certifying should be the focus of the remainder of the project.

Testing should be approached to first determine the "state-of-the-art" in the measurement of all components of competence -- motivation, attitudes,

skills, and knowledge. Subsequently, contracts should be negotiated for at least a pilot assessment of a few components.

Mobilization of the several constituencies should proceed in tandem with the test development. Advisory and interest groups should be identified and assembled to commence the design and structure of a certifying organization. It is proposed that these groups should be quite broad and include representatives from consumer agencies and advocates, worker and professional organizations, unions, personnel systems, government agencies, training programs,credentialing groups, etc.

Furthermore, many decisions, for example, the design of the credentialing organization and the weighting of individual competency statements, should not be done by a single person or small group. Broad participation by many groups in the decision-making process is essential to avoid tagging the project as serving the interest of a narrow group and not the larger society.

SUMMARY AND RECOMMENDATIONS

SUMMARY

Phase one of the Paraprofessional Worker Certification project intended to define and describe the content and characteristics of mental health/human service work. This has been done utilizing empirical data collected in several earlier related projects. These data have been subjected to two forms of validation on a national basis. The first was to obtain worker responses at task level. That is, workers in the field indicated the frequencies with which they perform a wide collection of tasks embracing this field of work.

These data were analyzed through the use of hierarchial grouping statistical procedures. This technique grouped related tasks into clusters. Competency statement constructs were derived from these clusterings which describe activities within broad contexts and settings.

A second national validation of the collection of 40 competency statements was carried out. As part of this process, scaled data were obtained which identified the relative frequency, importance to client, and potential risk to client (if poorly done) for each competency performed by mental health/human service workers. Alsc, respondents identified the level of worker currently performing each of the competencies. Respondents included a number of supervisors and educators as well as workers.

Analysis of survey returns to the competency statement validation suggests that the collection of statements provides a complete coverage of mental health/

human service work. Some statements are more crucial than others in meeting client needs. The amount of potential risk to the client if the competency were to be poorly done also varies fairly widely. Responses suggest that there is relatively weak basis for partitioning mental health/human service work into levels -- much less than assumed by existing personnel systems and practices.

RECOMMENDATIONS

This phase of the project has defined the behavioral content of mental health/human services work. The foundation for a performance-based credentialing system is now available for those individuals who make up the majority of direct service providers. The subsequent phases of the project can now build upon this empirical base in designing the assessment processes and the organization to carry out the credentialing.

Assessment of these activity or competency statements should be built around performance measures. Simulation, especially video-based, seems most promising in this area. Documentation of past performance along with work-adaptive skills and values/attitudes also holds promise to expose more of the processes to view. Progress in assessment of performance will likely advance through "successive approximations." A mix of paper/pencil testing for applied knowledge performance testing, and portfolio documentation appears to hold the greatest promise.

APPENDIX 1

WORKER ACTIVITY (COMPETENCY) STATEMENTS

as finally revised

Competency Statement 01

ELIGIBILITY DETERMINATION

Statement: Worker obtains information from client in order to determine eligibility for receiving and paying for services.

Interpretation: This is a frequently performed and critical competence because it is basic to determine who receives services and the ultimate source of payment including third party payers, i.e., Medicaid, Medicare, and insurance. Inquiry is specific, yet sensitive to client's value system and rights. Data obtained is usually recorded on a standard form.

Context: This might be carried out with a client or family member in cases such as children, psychotic or retarded persons. It applies to all types of clients and in all types of settings. Although no time constraints apply, the direct inquiries usually are conducted in a single session. Level characteristics: Technical.

Indicators:

1) Worker meets and greets client, determines need, and explains objectives and client's rights in order to facilitate information flow and reduce client anxiety.

2) Worker describes agency and programs.

3) Worker uses language and expressions that client can understand.

4) Worker maintains attentive behavior.

5) Worker "reads" and responds to "feeling tones" of client.

6) Worker elicits information in a neutral and objective manner.

7) Worker asks for relevant information, such as veteran's status, naturalization/date of entry, employment record, social security number, and past and present marital status, in sufficient depth to provide relevant information needed and prompts client as necessary to promote recall.

8) Worker records and reviews data with client to assure accuracy.

9) Worker interprets certification or other declaration to assure client understanding and agreement prior to eliciting signature, when required.

10) Worker informs client of possible future events and expectations, verifies client understanding, and closes interview.

11) Worker processes data to supervisor and colleague(s) as required by organization policies and procedures.

Competency Statement 02

BEHAVIORAL TECHNIQUES

Statement: Worker shapes client's behavior in order to substitute appropriate behavior for maladaptive behavior.

Interpretation: This is a frequent and important treatment competency. The competency is widely utilized in nearly all mental health/human services programs. The competency may be inclusive or part of a total treatment program. Behavior induced may be a substitute for an inappropriate behavior, or may be an entirely new behavior.

Context: This competency applies to a broad range of clients in all treatment settings. There are time constraints as depicted by a specific schedule of frequencies, trials, and behavioral goals. Level characteristics: Technical.

Indicators:

1) Worker initiates or continues effective relationship with client.

2) Worker uses techniques called for by service plan.

3) Worker identifies goal behavior and/or behavior to be extinguished and pertinent frequency.

4) Worker counts and records frequency of target behavior or maladaptive behavior to establish baseline.

5) Worker explains program, objectives and goals to client and obtains client's assent and commitment.

6) Worker negotiates reward system with client.

7) Worker establishes procedures for recording progress.

8) Worker processes data to supervisor or colleague(s) as required by organization policies and procedures.

Competency Statement 03

PREPARATION FOR TRANSITION

Statement: Worker explains anticipated events relating to service plan and what is expected of and by the client in order to prepare client for transition to a subsequent phase.

Interpretation: This is a commonplace competency that occurs frequently. The client's understanding of events is essential to obtain cooperative participation and involvement. Similarly, acceptance and informed participation will serve to reduce the client's anxiety and heighten motivation towards successful dealing with problems.

Context: This competency applies to a wide range of clients and service plans. A family member or guardian may substitute for the client. Generally, the competence is of short duration and occurs in reasonably close time proximity to the anticipated events indicated in the service plan prepared by team effort. Level characteristics: Technical. Difficulty/complexity may extend beyond usual level when working with chronic clients.

Indicators:

1) Worker initiates or continues effective relationship.

2) Worker explains the rationale, accurately outlines and identifies the choices, proposes activities, time and cost conditions, roles, expected outcomes, and possible risks to the client.

3) Worker maintains attentive behavior.

4) Worker "reads" and responds to the "feeling tones" of the client.

5) Worker uses language and expressions that the client can understand.

6) Worker asks the client for suggestions for his own participation in the plan.

7) Worker asks client (family) to report what they understand and responds to points not understood.

8) Worker obtains client's specific agreement and commitment to an agreed-upon plan.

9) Worker informs client of probable future events and expectations, verifies client understanding, and closes interview.

10) Worker inititates renegotiation of service plan contract, if necessary.

11) Worker processes data to supervisor or colleague(s) as required by organization policies and procedures.

Competency Statement 04

PLANS SERVICE DELIVERY PROGRAM

Statement: Worker plans and develops politics and procedures for a service delivery program in order to insure responsiveness, efficiency, quality, and accountability.

Interpretation: This is an essential competency, utilized intensively in the initial stages of program development to insure effective planning, program implementation, maintenance, and evaluation to meet the identified service need.

Context: This competency could relate to a multi-faceted or a limited specialty program operating in any human service setting. It is frequently carried out under time limits often imposed externally. The worker is generally constrained by limited resources, locations, and political considerations. Level characteristics: Associate-Professional.

Indicators:

1) Worker gathers data that identifies and establishes need for new program.

2) Worker reviews and evaluates data, and identifies responsive program characteristics.

3) Worker reviews literature and/or resources regarding similar needs or program responses.

4) Worker identifies necessary budgeting, staffing, equipment, supplies, and physical plant resources.

5) Worker identifies training and/or staff development needs for new program.

6) Worker identifies legal and political considerations.

7) Worker proposes planned service program to Board of Directors, public officials, granting agency, or public to gain support.

Competency Statement 05

EXPLAINS SERVICE PLAN

Statement: Worker explains and interprets service plan recommendations to client and/or family in order to achieve client's understanding, acceptance, and commitment.

Interpretation: This is a critical competency of a mental health/human service worker because the client's and family's understanding and acceptance of the treatment process is basic to progress toward resolution of the problem. This must be done clearly and understandably and yet sensitively. The worker must assure that the client and family understand and consent to the treatment after being fully informed of the findings and alternatives. The emotional reactions of the client and family must be fully sensed and explored before they can be fully assured and assent to the service plans.

Context: This might be carried out with any mental health client and/or family capable of participating in the service contract. It might be carried out in any setting. There are no particular time constraints. The service plan would generally have been outlined by the service team after earlier evaluation studies have been carried out. Level characteristics: Technical and Associate-Professional.

Indicators:

1) Worker meets and greets client, determines need, and explains objectives and client's rights in order to facilitate information flow and reduce client anxiety.

2) Worker maintains attentive behavior.

3) Worker "reads" and responds to the "feeling tones" of the client (e.g., anxiety, hostility, rejection, distrust, or fear, etc.).

4) Worker uses language and expressions that the client can understand.

5) Worker explains the rationale, accurately outlines and identifies the choices, proposed activities, time and costs conditions, roles, expected outcomes, and possible risks to the client.

6) Worker asks client for suggestions for his own participation in the plan.

7) Worker asks client (family) to report what they understand and responds to points not understood.

8) Worker obtains client's specific consent and commitment to an agreed-upon plan.

9) Specific plans are made for the next step.

10) Worker processes data to supervisor or colleague(s) as required by organization policies and procedures.

Competency Statement 06

PERSONAL LIVING SKILLS

Statement: Worker trains client in personal self-help and living skills or re-motivates in order to develop independent self-care.

Interpretation: This is a critical competency of mental health/human service workers because independent self-care is an essential first step to health, self-determination, and interpersonal relationships. The competency is essential and frequently performed. It is a critical activity and generally would occur early within a therapeutic program.

Context: This might be carried out with any client or family deficient in grooming, hygiene, money management, mobility, work, manual or recreational skills. It might be carried out in an out-patient, community, or residential setting. There are no specific time constraints, although follow-up to assure retention and practice by the client of the learned skills is implicit. The skill development would generally be indicated as an early objective component of a team-developed service plan. Level characteristics: Technical. Difficulty, especially objective when working with clients having chronic conditions, may exceed routine levels of difficulty/complexity but under greater supervision/specification than that for Associate-Professional level.

Indicators:

1) Worker initiates or continues effective relationship.

2) Worker uses written service plan.

3) Worker has identified specific teaching-learning goal.

4) Worker includes explanation, demonstration, application, and evaluation.

5) Worker directs communication to capabilities of learner.

6) Worker utilizes environment that enhances learning (e.g., concentration, comfort, lack of distractions).

7) Worker plans learning tasks in increments appropriate to client level of functioning.

8) Worker utilizes effective reinforcement.

9) Worker processes data to supervisor or colleague(s) as required by organization policies and procedures.

Competency Statement 07

DATA HANDLING/CASE PLANNING

Statement: Worker makes contact with client and collects and compiles information needed in order to assess and propose service plan.

Interpretation: This is a frequent, essential and critical competency to insure completeness of therapeutic planning of services. It is the basic building block for all case planning, management, and service delivery. The competency applies to all residential and community programs.

Context: This might be carried out with any assigned client in any setting. The planning may be at the sole discretion of the worker, may require supervisory approval, or may be recommendations made to team staffing. Generally, this competency is of short duration and occurs as close to entry into services as procedures, resources, and policies allow. The competency may involve client and/or family, as well as other community resources (e.g., referral data, school reports, hospital records, etc.). Level characteristics: Technical and Associate-Professional. Administration, scoring and interpretation of psychometric assessment normally would be limited to Associate Professional level.

Indicators:

1) Worker collects and reviews all available data relevant to client.

2) Worker interviews client.

3) Worker meets and greets client, determines need, and explains objectives and client's rights in order to facilitate information flow and reduce client anxiety.

4) Worker "reads" and responds to "feeling tones" of client.

5) Worker elicits information in a neutral and objective manner.

6) Worker uses language and expressions that the client can understand.

7) Worker maintains attentive behavior.

8) Worker reaches for information pertinent to problem assessment (i.e., school history, family work history, etc.) and service delivery.

Competency Statement 08

CONDUCTS ACTIVITY PROGRAM

Statement: Worker plans and conducts activity program in order to maintain or improve client's physical, social, and emotional functioning.

Interpretation: This competency is both common and critical. It applies to residential and community programs. It may be a specific part of an individual client's service and rehabilitation program or it may be general and intended to maintain a current level of functioning.

Context: This may be carried out by a single worker or group of workers with any single client or group of clients. It may be carried out in a wide range of locations. The program may be ongoing for a group of clients, although specific activities may be spontaneous, preplanned, seasonal, or periodic. The activities involved in this competency are very wide-ranging and may include games, sports, parties, crafts, music, work, calisthenics, etc. Level characteristics: Technical and Associate-Professional. Programs with greater scope; programs involving the therapeutic application of difficult therapies, e.g., psychodrama or dome therapy; and programs involving control over groups of clients with high potential for disregard of safety, those inclined to evade control or escape (legal holds) are generally the functions or responsibility of the Associate-Professional level.

Indicators:

1) Worker plans activities around the specific needs and interests of clients and/or service programs for:

   A) Physical or work activities;
   B) Social interactions and social skill development;
   C) Recreational activities.

2) Worker plans activities with consideration to the physical limitations and capabilities of clients.

3) Worker utilizes available resources to full and creative advantage.

4) Worker identifies and arranges for people resources, equipment, and supplies needed for planning and implementing program.

5) Worker prescribes safety requirements, teaches safe use of equipment and safe procedures, and monitors clients closely to assure client safety.

6) Worker encourages and supports clients engaging in activities.

7) Worker processes data to supervisor and colleague(s) as required by organization policies and procedures.

Competency Statement 09

SERVICE REFERRAL

Statement: Worker refers client in order to link client with another service.

Interpretation: This is a common and frequent competency for workers in settings who must help their clients obtain inter- or intra-agency resources and services.

Context: This competency may be carried out with all types of clients and/or members of their families and in a wide range of settings. The referral may be made to a broad range of institutions, community-based programs, private practitioners, or other services within the agency. There are no particular time constraints, however, the client contact would likely be completed in one or two sessions. Level characteristics: Technical and Associate-Professional.

Indicators:

1) Worker initiates or continues effective relationship.

2) Worker elicits information in a neutral and objective manner.

3) Worker determines that client understands the nature of the agency to be utilized and the service to be performed, the costs, the time required.

4) Worker obtains client's consent and commitment and verifies understanding of the referral processes.

5) Worker establishes with client (family) the responsibility for the referral process, such as telephone or written contact of the agency to be utilized, transportation, making appointments, etc.

6) Worker contacts receiving agency, determines availability of services, and provides necessary information.

7) Worker establishes follow-up plan and follows through to assure client receives services.

8) Worker processes data to supervisor or colleague(s) as required by organization policies and procedures.

Competency Statement 10

PROBLEM IDENTIFICATION-LINKAGE

Statement: Worker interviews client, obtains information, and identifies problem in order to propose course of action.

Interpretation: This is a critical competency for the mental health/human services worker. The competency calls for obtaining a wide variety of information that will permit judgment in identifying or verifying the core problem of the client in order to provide an appropriate service. A facilitating relationship must also be established with the client that will elicit factual information and feelings in order to properly identify the client problem. The competency includes any client that is self-referred or referred from a community agency or other person.

Context: This competency might be carried out with any client or family member. It may be carried out in any mental health service setting. There are no particular time constraints other than those of responsiveness, efficiency, and economy. Level characteristics: Technical and Associate-Professional. Interpreting test results soliciting information from outside agencies, and proposing or adopting treatment plan may be at the Associate-Professional level.

Indicators:

1) Worker meets and greets client, determines need, and explains objectives and client's rights in order to facilitate information flow and reduce client anxiety.

2) Worker asks client to explain his/her perception of the problem.

3) Worker explores beyond information provided by client.

4) Worker maintains attentive behavior.

5) Worker uses language and expressions that the client can understand.

6) Worker "reads" and responds to "feeling tones" of the client.

7) Worker elicits information in a neutral and objective manner.

8) Worker provides feedback to client to verify understanding of information, makes judgments about problem, and proposes course of action to client for assessment and commitment.

9) Worker informs client of probable future events and expectations, verifies client understanding, and closes interview.

10) Worker processes data to supervisor or colleague(s) as required by organization policies and procedures.

11) Worker obtains client information through testing and outside sources in order to obtain information for proposing course of action.

12) Worker reviews information received from referral sources and corroborates if necessary.

13) Worker notifies referring agency of client case disposition within constraints of applicable confidentiality policies and laws.

Competency Statement 11

NURTURES CLIENT

Statement: Worker nurtures client in order to maintain the client's physical and emotional functioning or to prevent further regression.

Interpretation: This is a common and frequently performed competency. It is essential and applies universally in that client physical functioning is basic to sustain life. Emotional functioning is strongly intergrated with physical well-being, and thus, must also be nurtured to enhance the effectiveness of other treatments.

Context: This competency applies to all types of clients and client problems in all settings. The care provided for non-resistent clients may be a mere awareness that the client's physical and emotional needs are being met. For clients needing institutional or custodial care, the competency may include full personal care, sustenance and maintenance of the quality of life. No particular time constraints apply, the competency is essentially continuous in nature. Level characteristics: Technical. The complexity of client problems and the difficulty in ministering to client needs may extend through the entire range. The degree of prescription, supervision, and availability of assistance in such cases probably would leave little discretion to the worker.

Indicators:

1) Worker initiates or continues facilitative (effective) relationship.

2) Worker maintains attentive behavior.

3) Worker "reads" and responds to the "feeling tones" of the client.

4) Worker uses language and expressions that the client can understand.

5) Worker monitors, records, and/or reports vital signs.

6) Worker feeds or supervises client feeding.

7) Worker bathes and grooms or supervises client bathing and grooming.

8) Worker controls acting out of violent behavior to protect client and others from physical or emotional harm.

9) Worker schedules and supervises clients assigned to work.

10) Worker observes client for signs of impending deviant behavior and intercedes when appropriate or called for in service plan.

11) Worker performs body check for scars, bruises, etc.

12) Worker dispenses and administers prescribed medication according to legal guidelines.

13) Worker conducts social and exercise activities.

14) Worker observes and reports side effects of medication.

15) Worker escorts clients to and from internal and external locations when necessary.

16) Worker does reality testing.

17) Worker processes data to supervisor or colleague(s) as required by organizational policies and procedures.

18) Worker monitors and encourages toilet habits (both urine and bowel functions).

Competency Statement 12

MONITORS MEDICATION

Statement: Worker dispenses and/or monitors medication taken under medical supervision and motivates client to take prescribed medication in order to enhance treatment.

Interpretation: This is a very frequent competency, essential whenever pharmacological agents are utilized.

Context: This competence applies to all clients for whom psychotrophic drugs are prescribed as part of service plan. It applies to both insititutionalized and community-based clients. Time constraints may be imposed by medical needs, or by staffing schedules. The competence may be a short-term or ongoing process requiring continuous monitoring and follow-up. Level characteristics: Technical. State laws may limit functions of workers.

Indicators:

1) Worker is knowledgeable regarding properties of drugs being dispensed, their potential side-effects and client rights relating to taking or refusing medication.

2) Worker initiates or continues facilitative relationship with client.

3) Worker determines medication history from records, client, and family.

4) Worker explains importance of medication to client and family and explains effects, possible side-effects, schedules, and expectations.

5) Worker dispenses medication according to service plan to resident client.*

6) Worker observes resident client taking medication and checks mouth to be sure oral administered medication has been swallowed.*

7) Worker reads and records client vital signs, queries/observes for side-effects or toxic reactions to medication, and takes appropriate action, (referral to physical or reassurance of client).

8) Worker assures an adequate supply of medication for non-institutionalized clients.

9) Worker proposes safeguards of medication usage and storage for non-institutionalized clients to prevent overdose.

10) Worker records medications administered, its effect and processes data to supervisor or physician as required organization policies and procedures.

*For acute in-patient services and where law permits.

Competency Statement 13

TRANSFER RESPONSIBILITY

Statement: Worker orients colleagues to current services and client's functioning or status in order to transfer responsibility for daily activities and/or shift assignments.

Interpretation: This daily competency is essential in institutional programs but may also apply to other service programs. It is critical that there be orderly transfer of responsibility in order to provide continuity of care for clients. It may occur at shift changes or when clients return from recreational or occupational programs away from the living unit.

Context: This competncy applies to residential and day care programs for all types of clients. Time constraints vary from setting to setting, but generally do not exceed an hour's time. Major content of the briefing is usually prescribed by unit policy. However, considerable discretion is left to the worker, especially as pertains to individual clients. A review of records, such as individual service plans and nursing notes, normally is included. Level characteristics: Technical and Associate-Professional.

Indicators:

1) Worker reports new admissions, transfers, and/or discharges occurring during the time period being reported.

2) Worker reports changes in service plan, including medications and new procedures, ocurring during the time period or activity.

3) Worker reports any critical incidents that occurred during the time period and actions taken.

4) Worker reports present status of each client to include: behavior, problems, attitude, participation, interest, client suggestion, etc.

5) Worker reports changes in clinical, administrative, and/or personnel procedures ocurring during the time period.

6) Worker jointly inventories controlled drugs and transfers responsibility for keys and other controlled items according to prescribed procedures.

7) Worker reports logistical changes, hazards, etc., that occurred during the period.

8) Worker communicates any specific orders, expectations, concerns, etc., to be carried out, monitored, evaluated. etc., by the receiving staff.

Competency Statement 14

ADVOCATES FOR NEW PROGRAMS

Statement: Worker plans and advocates for a new service program within an existing system or one based in the community. Advocates with system colleagues, agency officials, community leaders, possible funding sources and other significant persons to gather support for the new program.

Interpretation: This is an important competency that attempts to fill the identified needs of a specific group(s) of clients for programs or services that are not available to them. The need must be defined and substantiated and the proposed program must be related to the specific need. Administrative, financial, legislative and/or community support must be developed to obtain the resources and sanctions necessary to implement the service program.

Context: This competency might be carried out in any part of the existing service delivery system and for any group of clients. It might be initiated informally at first, and as planned, become a formal effort. Generally, the context of the client systems competency would be reduced to writing as the planning and advocating become more formal. There are no specific time constraints. The competency would generally extend over a period of several months. Level characteristics: Associate-Professional.

Indicators:

1) Worker identifies unmet mental health/human service need.

2) Worker documents specific cases of unmet client needs and provides data regarding frequency, characteristics of clients needing service, etc.

3) Worker discusses proposed program with and elicits support from:

   A) Supervisor;
   B) Colleagues;
   C) Clients;
   D) Lay individuals;
   E) Public officials;
   F) Client advocate groups.

4) Worker develops written plan containing:

   A) Need identification;
   B) Proposed services or program;
   C) Eligibility requirements;
   D) Resources required
      1) financial
      2) logistics
      3) staff
      4) new training
      5) facilities
   E) Legal sanctions;
   F) Community support or involvement.

5) Worker formally presents proposal to various groups.

6) Worker organizes and coordinates lobbying efforts to gain support for the proposal.

Competency Statement 15

MONITORING CLIENT PLACEMENT

Statement: Worker arranges and/or monitors community residential placement of client in order to assure adjustment and progress.

Interpretation: This is a frequent and important human service/mental health competency. It is critical to the effectiveness of treatment follow-up when the worker is generally the only linkage between institutional and/or community programs.

Context: This competency pertains to a broad range of clients who are placed for residential care within half-way houses, group homes, boarding homes, or in private residences. The client may be a new client or one being transferred from residential treatment within a similar agency. The client may come from a state hospital, alcohol or drug facility, mental retardation or correctional facility. Time limitations do not usually apply. Monitoring may include not only the client, but also staff, family or friends, other community resources, and the physical environment. Higher level competence applies when monitoring is part of regulating, e.g., state inspection for granting, renewal or withdrawal of facility license. Level characteristics: Technical and Associate-Professional.

Indicators:

1) Worker meets and greets client, staff, and/or family members, determines need, and explains objectives and client's rights in order to facilitate information flow and reduce client anxiety.

2) Worker maintains attentive behavior.

3) Worker initiates or continues facilitative relationship.

4) Worker "reads" and responds to the "feeling tone" of the client.

5) Worker uses language and expressions that the client can understand.

6) Worker prompts client, family and/or staff to provide specific comments pertaining to:

   A) Service program;
   B) Recreation and social activities;
   C) Security and fears;
   D) Food;
   E) Visitation;
   F) Mail;
   G) Complaints and compliments;
   H) Work activities;
   I) Spiritual activities.

7) Worker observes and evaluates physical facilities and environment:

   A) Temperature and lighting;
   B) Clothing, bedding, and laundry facilities;
   C) Furniture and general appearance;
   D) General atmosphere and safety;
   E) Emotional atmosphere;
   F) Food and nutritional program;
   G) Activity/recreational program.

8) Worker asks client for suggestions for his own participation in the plan.

9) Worker asks client (family) to report what they understand and responds to points not understood.

10) Worker counsels client regarding specific adjustment problem(s).

11) Worker obtains client's specific consent and commitment to an agreed-upon plan.

12) Worker informs client of probable future events and expectations, verifies client understanding, and closes interview.

13) Worker processes data to supervisor or colleague(s) as required by organization policies and procedures.

Competency Statement 16

TEAM REVIEW

Statement: Worker presents and/or coordinates presentation of all pertinent client information and participates in the team review in order to develop plan or evaluate service.

Interpretation: This is a critical and continuous competency of the mental health/human service worker that is basic to most client services. Initial diagnosis, service planning, goal setting, periodic review, and evaluation rely upon consideration of all available client information in a multi-discipline setting which may include the client. Decisions are usually consensual and result in a written service plan having specific goals, schedules, and assignments of responsibilities.

Context: This competency is appropriate to all clients and in all settings which utilize a team approach to case management. The "staffing" team would be composed of an appropriate representation of all disciplines and direct service personnel involved in providing service. Meetings may be routinely scheduled, or spontaneously called, to deal with new clients, crisis intervention, or new data. Level characteristics: Technical and Associate-Professional. Assignment of staff, a supervisory function, would likely be at Associate-Professional level.

Indicators:

1) Presents complete facts, observations, and critical incident information regarding client in objective manner; offers personal interpretations and opinions at appropriate times.

2) Presents diagnosis and/or interpretation data with identification.

3) Presents data reliability information whenever the source is potentially biased or of questionable veracity.

4) Suggests hypothesis for client's problem diagnosis.

5) Relates own experience with similar clients or problems to the team for consideration.

6) Asks for information and observations of other team members and client suggestions and encourages discussion.

7) Proposes service goals, therapeutic interventions or procedures pertinent to the client's problem(s), circumstances and capabilities.

8) During periodic team reviews, analyzes critical incidents and the client's behavior in relation to pre-service baseline observations and service goals in order to evaluate the client's progress.

9) Participates in team decision-making regarding the development or modification of an individualized plan for the client.

10) Identifies other client information of observations to be obtained for future team review and identifies plan for obtaining and presenting.

11) Worker processes data to supervisor or colleague(s) as required by organization policies and procedures.

Competency Statement 17

CLIENT ADVOCACY

Statement: Worker defends, promotes and/or pleads a service-related right, cause and/or need as identified by the client(s) in order to influence decision/solution favorable to the client(s).

Interpretation: This competency is a frequent and essential mental health human service competency. It can be utilized in most conflict situations which affect and/or interfere with service(s) and/or acquisition of needed supports. This competency can go beyond externally imposed regulations/guidelines of agency treatment facility, systems, or societal constraints as the worker is advocating exclusively for the client in this competency and is not working for agency, supervisor, society, etc. This competency may involve a broader stand in favor of humanization of services/program.

Context: This competency applies to all types of clients in all settings. It frequently involves the family or a group/class of clients with the same client-identified cause or need. There are no formal time constraints although this competency may be viewed as usually being of shorter duration when dealing with an individual client's need and/or cause than when dealing with those of a group or class of clients. Any limits that would be imposed on the worker/advocate are essentially self-imposed (i.e., commitment, own attitudes and values, conflict and confrontation skills, knowledge of applicable target system) as the nature of advocacy circumvents externally imposed limitations. Level: Technical and Associate-Professional. Advocating for a class of clients, especially outside of the worker's own agency generally would pertain to the Associate-Professional level.

Indicators:

1) Worker meets and greets client, explains objectives and client's rights to order to facilitate information flow and to reduce client anxiety.

2) Worker initiates or continues effective relationship with client(s)/family.

3) Worker uses language and expressions that client(s)/family can understand.

4) Worker elicits information, cause/need in a neutral and objective manner.

5) Worker explains rationale, accurately outlines and identifies the choices, proposed activities, time and cost conditions, roles, expected outcomes, and possible risks to the client.

6) Worker asks client, family, or group of clients for suggestions for his/her participation and commitment in the plan.

7) Worker clarifies client(s)/family stated cause/need and formulates goal in broad and general terms.

8) Worker chooses and/or adapts any or all of the following specific tactics/strategies that he/she personally feels comfortable with and is committed to.

   A) Focuses on major goals--details follow change;
   B) Identifies adversary by name; personalizes him/her; makes him/her target; polarizes self from adversary;
   C) Knows issues, supporting allies and sources of information in order to handle the often penetrating and hostile questions that arise concerning an issue;
   D) Promotes the development of a procedure for administrative review and redress of decisions to provide a vehicle for confronting (diplomatically or otherwise) the administration with facts concerning the issue;
   E) Offers the adversary a constructive alternative in keeping with his/her own change commitment goals;
   F) Analyzes goals realistically--frequently calling for a change may bring about a more realistic compromise;
   G) Keeps the pressure on--varying the tactic prevents boredom and is more difficult for the adversary to adjust to;

H) Capitalizes on not only what he/she has, but what your adversary thinks;
I) Goes outside adversary's realm of experience while staying in own frame of reference and client's;
J) Insists that the adversary live up to his/her own rules;
K) Teaches the client to advocate for him/herself and mobilize his/her allies;
L) Builds on client's dignity. Emphasizes that by meeting his/her responsibilities, he/she will have a legitimate claim to his/her rights.

9) Worker confers with service system, allies/colleagues, and informed persons to build target knowledge base.

10) Worker builds social relationships through face-to-face contacts with agency personnel, later eliminating going through established "red tape" channels.

Competency Statement 18

MONITORS TREATMENT

Statement: Worker observes and monitors client undergoing physical treatment in order to stabilize client's condition.

Interpretation: This competence is performed frequently and is important with clients with chronic illness or disease, recently acquired traumas, or medical emergencies, such as detoxification, seizures, overdoses of medications, etc. It is a critical phase of treatment requiring close and continuous observation and interpretation.

Context: The competency pertains to physically ill, injured, or chemically addicted clients. The condition being treated may have many causes, such as disease, overdose of medications, poisoning, trauma, etc. All types of clients are included. The competency applies only within an institutional setting, under medical supervision and within the legal guidelines of institution/state. Time constraints may be imposed by the physical problems, the medical treatment required, or the client's response to medication. Level characteristics: Technical.

Indicators:

1) Worker observes and monitors client's vital signs.

2) Worker reports all observation ouside limits prescribed by standard procedures or specific instructions of the supervisory physician.

3) Worker controls thrashing or other potentially harmful physical behavior in accordance with institutional policies and procedures.

4) Worker observes for and records/reports indication of delirium tremors, hallucinations, confusional states, or changes in emotion.

5) Worker initiates or continues facilitative (effective) relationship.

6) Worker empathizes with the client, offers reassurance, interprets client symptoms, and explains what is happening.

7) Worker seeks to gain client's cooperation in eating, taking fluids, medications, etc.

8) Worker monitors and ensures toilet habits (i.e., urine and bowel functions).

9) Worker exercises patient (by walking, etc.) to prevent pneumonia if condition lasts beyond 24-48 hours.

10) Worker provides opportunities for bathing and grooming within limits of client's abilities.

Competency Statement 19

GROUP THERAPY

Statement: Worker leads, co-leads, and/or participates in group therapy sessions in order to provide new learning experiences; to enhance socialization and interaction; and to develop or increase independent behavior functioning and problem-solving.

Interpretation: This competency is frequent and important. It is a basic therapeutic modality that may be the only service need for a particular client or one part of a service program. The group may be constituted for direct therapeutic purposes and specific goals or it may be ancillary and utilize commonplace assemblages, such as meals or recreational gatherings.

Context: The competency applies across all mental health/human services programs and clients. It applies to both residential and non-residential programs. Groups may contain more than a single staff member with or without a formal division of responsibilities. Client family members may be included. Group membership may be consistent or new members may be added periodically. Time constraints are those imposed by the group staff, or by service plan. Level characteristics: Technical and Associate-Professional. It is anticipated that responsibility for therapeutic group leadership would generally be the function of the Associate-Professional level worker.

Indicators:

1) Worker clearly defines goals, structure, and limits of group.

2) Worker fosters that invitation and sustainment of trust-building relationships within the group.

3) Worker fosters involvement participation and responsibilities of all group members.

4) Worker draws out client feelings and encourages the release of tension and anxieties (catharsis).

5) Worker facilitates reality-based feedback to clients.

6) Worker explains the rationale, accurately outlines and identifies the choices, proposed activities, time and cost conditions, roles, expected outcomes, and possible risks to the client.

7) Worker asks client for suggestions for his or her own participation in the plan.

8) Worker reduces excessive group pressure upon a single client (i.e., scapegoating or overwhelming).

9) Worker evaluates and critiques group session with other participating staff.

10) Worker assists participants to learn effective interpersonal behavior within the group.

11) Worker records significant episodes in client records or nursing notes, as required by policy and procedures.

12) Worker processes data to supervisor or colleague(s) as required by organization policies and procedures.

Competency Statement 20

FISCAL MANAGEMENT

Statement: Worker programs, allocates, and accounts for client and service unit's funds to manage monetary resources.

Interpretation: This is a frequently performed and critical competency because it is basic to the control and management of client accounts and agency funds allocated for operation of a service program. The functions are informal (generally a formal set of "books and accounts" would not be used) and cyclic, that is, resources would be requested, approved and allocated periodically, e.g., quarterly and annually. Expenditure reports would also be required periodically. Informal bookkeeping would be continuous.

Context: This competency applies to all organizational program elements of an agency or institution where all or part of financial resources are suballocated to teams, programs, or unit managers or where client accounts are maintained. Time restraints established by organizational financial policies apply to fiscal programming, allocating and reporting. It includes the establishment and maintenance of client's personal and reimbursement accounts. Level characteristics: Technical and Associate-Professional. It is anticipated that generally the accounting (clerical) is at the Technical level and the programming and allocation (managerial) is at the Associate-Professional level.

Indicators:

1) Worker safeguards and maintains accurate record of all agency and client funds entrusted to team or unit.

2) Worker reports and follows-through to assure that all client and unit reimbursable entitlements are reported, credited and properly accounted for.

3) Worker reviews expenditure requests for proper authentication and/or approval prior to reimbursement.

4) Worker prepares and submits required periodic reports.

5) Worker reports improper expenditures, missing funds or documents, or other irregularities in procedures.

6) Worker informs clients and/or co-workers about procedures for planning, disbursing and accounting for client agency funds.

7) Worker responds to administrative and client inquiries about status of funds.

8) Worker plans future service program budget in accordance with executive guidance.

9) Worker justifies and defends proposed budget to supervisors, executive or appropriate committee.

10) Worker informs colleagues/subordinates of resources allocated for program budget period.

11) Worker establishes expenditure control and bookkeeping procedures.

12) Worker monitors and reviews accounting and corrects or reports improper expenditures, missing funds or other irregularities as required by organizational policies and procedures.

13) Worker justifies and processes requests for additional funds as required by organizational policies and procedures.

Competency Statement 21

FACILITATING CHANGES IN CLIENT BEHAVIOR

Statement: Worker initiates change in the client's behavior in order to assist client to attain independent, satisfying functioning in the community.

Interpretation: This competency is at the core of all human service efforts. The nature, scope and complexity of the behavior to which the worker's efforts are directed may be as limited as toileting or toothbrushing or as expansive as reality orientation. The criticality of worker effort is a function of the immediacy and nature of client need.

Context: Applications of this competency will be found in any context in which an individual is encountered in the role of client. Strategies for facilitating client behavior change may be employed in one-to-one situations between the worker and the client or in group contexts, including family groups, task-oriented groups (such as house meetings, ward meetings, peer courts, etc.), counseling or therapy groups, and skill- or knowledge-focused groups. The duration of the worker's effort varies, depending on the developmental capabilities of the client and the intervention stragegy used to facilitate the behavior change. Level characteristics: Technical and Associate-Professional. It is anticipated that Professional-Associate level of functioning would involve responsibility for groups of clients, approval and initiation of treatment plan, assigning tasks and evaluating performance of sub-ordinates.

Indicators:

1) Worker meets and greets client and/or family, explains objectives and client's rights in order to facilitate information flow and reduce client anxiety.

2) Worker initiates or continues facilitative relationship.

3) Worker maintains attentive behavior.

4) Worker "reads" and responds to the "feeling tones" of the client.

5) Worker uses language and expressions that the client can understand.

6) Worker protects the client's rights to privacy and confidentiality at all times.

7) Worker encourages client compliance with routines and schedules.

8) Worker maintains facilitative environment.

9) Worker promotes client's awareness of "reality."

10) Worker instructs and guides client behavior required for independent functioning (e.g., personal hygiene, self-care, eating habits, money management and mobility).

11) Worker reduces frequency, discourages or prevents undesirable client behavior.

12) Worker provides facilitative environment for client behavior change.

13) Worker recommends or administers medically prescribed behavior-altering medication in order to control client behavior.*

* Within limitation of institutional policy and state laws.

Competency Statement 22

OBSERVING, RECORDING, AND INTERPRETING BEHAVIOR

Statement: Worker observes, records, and interprets client behavior in order to acquire information useful in developing service program.

Interpretation: This is a frequently performed and critical behavior because it is basic to all problem-solving, decision-making and service intervention on behalf of the client. The modes of observation, recording, and interpretation used vary in scope and complexity from very simple and procedural to very complex and exploratory.

Context: This behavior is carried out with clients and family members manifesting the full range of behavioral, psychosocial, cultural and cognitive characteristics served in all kinds of programs. It may take place under prearranged conditions (e.g., a psychological test, a time-limited observation of a specific behavior, etc.) or as the occasion arises in the course of day-to-day interaction with the client (e.g., in therapy session, during meals or other activities, in a formal manner, etc.). Level: Technical and Associate-Professional. Observations, assessment, and interpretation of cognitive data obtained through testing and therapy usually would be at the Associate-Professional level.

Indicators:

1) Worker collects and reviews all available data relevant to client.

2) Worker meets and greets client and explains objectives and client's rights in order to facilitate information flow and reduce client anxiety.

3) Worker "reads" and responds to "feeling tones" of client.

4) Worker elicits information in a neutral and objective manner.

5) Worker uses language and expressions that the client can understand.

6) Worker maintains attentive behavior.

7) Worker reaches for information pertinent to problem assessment (i.e., school history, family or client work history, etc.) and service delivery.

Competency Statement 23

STAFF DEVELOPMENT/TRAINING

Statement: Worker identifies need, plans, conducts, and evaluates staff training in order to develop organization and proficient human resources.

Interpretation: This is a frequently performed competency essential to effective organizational functioning and a harmonious and efficient staff. The training may be formal, informal or a combination of both. The staff training envisioned here is that which is the inherent responsibility of all supervisors although a full-time training staff may be available for consultation and learning resources.

Context: This competency applies to all workers responsible for the performance of assigned staff (staff members, trainees, volunteers, and students placed for experiential learning). It applies in all settings and is continuous, that is, advanced learning objectives are identified as former goals attained. Level: Associate-Professional.

Indicators:

1) Worker orients staff to the organizational unit and program and identifies responsibilities and expectations.

2) Worker identifies training needs of individual staff persons.

3) Worker develops individual training plan with each staff person and schedules training.

4) Worker identifies and assists staff person to obtain learning resources.

5) Worker conducts individual and group instruction for staff in unit or team operations and subject/skill areas of own expertise.

6) Worker quizzes, examines, and critiques learning assignments, provides feedback, and offers constructive suggestions for mastery.

7) Worker periodically evaluates developmental progress of each staff person.

8) Worker seeks out learning opportunities elsewhere for staff.

9) Worker integrates training into service delivery routine.

10) Worker counsels staff members to assist in the identification of long-term career goals and developmental opportunities and encourages progress towards these goals.

11) Worker records and processes training-related data as required by organizational policy and procedures.

Competency Statement 24

CONSULTATION

Statement: Worker initiates, responds to requests for or maintains consulting relationship(s) with service colleagues in order to clarify and/or improve service delivery.

Interpretation: This is a critical and commonplace competency which occurs in and among all mental health/human service settings. The worker actively seeks and shares own opinions and views from and with other workers to substantiate diagnosis and proposed services, knowledge, skills and techniques regarding client/case issues and/or program procedural issues.

Context: The colleague envisioned in this competency is any experienced and knowledgeable person who can offer relevant assistance in the areas described above. The colleague may be the supervisor(s), treatment team members, or a knowledgeable person outside of the immediate service setting. The consulting may involve policy, law or treatment. Although this competency itself usually does not include direct client contact, it may revolve around a particular client or groups of clients. This competency may occur on a regular or continuous basis, both formally and informally in regard to time and format. Also, this competency is performed in an inter- and intra-agency context and involves both the giving and receiving of consultation. Level: Technical and Associate-Professional.

Indicators:

1) Worker is aware of and recognizes own limitations and responsibility in seeking and providing consultative help.

2) Worker organizes available information, such as client's/program's present status, strengths, and limitations, and is able to be specific about concerns and needs.

3) Worker seeks exterior opinion to corroborate problem identification and proposed service.

4) Worker reviews new or established procedures/policies/laws with colleagues.

5) Worker requests or provides clarification of specific operational information from or to a service system colleague(s) about the nature of a particular service/policy/procedure.

6) Worker discusses program activity, sharing administrative events/status with colleagues/supervisors/team members.

7) Worker instructs or receives instruction from colleagues about professional skills, knowledge, techniques, and methods.

8) Worker instructs, queries, reviews, clarifies, interprets, and evaluates case situation with colleague(s).

9) Worker initiates or facilitates effective consultative relationship.

10) Worker designs and plans format of consultative activities, considering stated needs/concerns, efficient use of time/materials, and own strengths and limitations.

11) Worker identifies, explains, and clarifies confidentially the issues of all consultative discussions when related to client cases.

Competency Statement 25

INTERACTIVE COMMUNICATION

Statement: The worker communicates with others in order to provide and receive information relevant to planning, evaluating and delivering services.

Interpretation: This competency is essential and critical because it is basic to the sharing of information on which program plans and service efforts are based.

Context: The competency being presented here is that required to talk, gesture, display, etc. in an interactive context. It does not include the specialized competencies required to produce recorded communications (i.e., writing, audio-tape, video-tape, etc.)

This competency is required in any context in which two or more individuals, e.g., clients, colleagues or members of the public-at-large, are engaged together (in person or by electronic means) in a process of sharing information. Level: Technical and Associate-Professional. Very little difference between the Technical and Associate-Professional levels exists. Communication difficulty may vary in situations involving individuals who have a speech impairment, are non-English speaking, and clients with severe dysfunctioning or deficiency in reality orientation. Generally, the content and purpose of the communication would determine the level of the competency.

Indicators:

1) The worker communicates in a language common to the person with whom he/she is interacting - compensating for the idiomatic, syntactic, and cultural characteristics of the other's communicative competency.

2) The worker monitors the behavior of the other indications that the other is receiving the message intended, and adjusts his/her communication.

3) The worker monitors his/her own behavior during the communication for indications that language used and behavior exhibited are congruent, and adjusts his/her language or behavior accordingly.

4) The worker monitors the physical and social environments in which the communication occurs for factors which distort or block the communications and adjusts the environment or the communication accordingly.

5) The worker uses terminology which accurately portrays the experience, observation or interpretation being conveyed in the information communicated.

6) Worker uses language and expressions understood by the intended other.

7) The worker listens to the other and observes the other's behavior during the communication.

8) The worker monitors his/her own understanding of the communication made by the other comparing this understanding to the behavior of the other or other information already known to the worker, and adjusts, as appropriate, his/her communicative process or understanding.

9) Worker communicates descriptively, objectively, and non-judgmentally information being conveyed which is intended to interpret the other's behavior.

10) Worker identifies information considered "factual" and information considered "interpretive" when appropriate to the other's understanding.

Competency Statement 26

SELF-DEVELOPMENT

Statement: Worker acquires new knowledge and learns new skills or improves old skills in order to maintain and insure efficiency.

Interpretation: This is a frequent and important competency. New knowledge may be updating of information or completely new discoveries, theories, etc. The skills may be new techniques, modification to existing techniques or enhancement of the quality of a performance.

Context: The competency applies to all workers in all settings. The learning may be formal as in a classroom or laboratory setting, attending a course, lecture, conference or workshop conducted on or off premises, or informal through reading or discussions with colleagues and professionals. The training may be part of planned career development, imposed or required by the employing agency or individual supervisor, or resulting from individual interest and initiative. Level: Technical and Associate-Professional. Assigned responsibilities and experience/education of worker would normally determine the level content for self-development efforts.

Indicators:

1) Worker actively seeks out training opportunities to improve self.

2) Worker actively participates in unit, institutional, and outside training in order to learn new knowledge and/or techniques.

3) Worker reads and studies the related professional literature during slack work periods and on own time to increase knowledge.

4) Worker queries colleagues and professionals concerning unusual cases, new or different procedures to understand and gain new knowledge.

5) Worker visits and studies other service agencies and programs in order to increase knowledge about community resources and their policies and procedures.

6) Worker practices skills and new techniques under guidance or supervision in order to improve skills and master new techniques.

7) Worker reviews and analyzes own work or behavior, sometimes consulting with colleagues or supervisors for errors, mistakes, or weaknesses in order to improve own performance.

Competency Statement 27

FACILITATING GROUP PROBLEM-SOLVING AND DECISION-MAKING

Statement: The worker facilitates the efforts of groups of staff/clients to solve problems and make decisions in order to prepare for actions designed with input from the collective wisdom of the group.

Interpretation: This is an important and frequent competence based on the belief that group problem-solving and decision-making are useful means of making optimum use of a group's experience and knowledge, as well as developing support for and commitment to the values, judgments and action decisions made in the process. Group problem-solving and decision-making are also considered useful means for providing experiential learning for skill-building in these areas.

Context: This might be carried on with staff or clients around service plans, agency policies and procedures, or other service-related issues including recreational activities, daily living activities, etc. The meeting(s) involved may occur on a regular schedule or ad hoc basis. The client might be of any type capable of participating. The competency might be carried out in any setting. Decision sought of problem presented might vary the level of the competency consistent with the level of authority and responsibility held by the worker leading the session. Level: Technical.

Indicators:

1) Worker identifies issue(s) around which group will meet and justifies relevancy of meeting.*

2) Worker identifies participant to be involved in the meeting.*

3) Worker notifies participants of meeting time/location and objectives.*

4) Worker presents the issues to the group.*

5) Worker informs the group of the problem-solving and decision-making approaches to be used.*

6) Worker facilitates the group's effort, acting as information provider, clarifier, gatekeeper, summarizer, etc., as appropriate.

7) Worker facilitates the development of an action plan for following-up unfinished business.

8) Worker evaluates meeting with staff/clients.

9) Worker processes data to supervisor/colleague(s) as required by agency policies and procedures.

*The manner in which these activities are carried out may themselves be determined in a group context--as a result of a group problem-solving/decision-making effort.

Competency Statement 28

FACILITATING LEARNING EXPERIENCES IN A GROUP SETTING

Statement: The worker facilitates or provides learning experiences for staff/clients in a group setting in order to promote the attainment of new skills or knowledge or to improve existing skills or knowledge.

Interpretation: This competency is important and frequent. Using a group setting to provide learning experiences is advantageous for at least two reasons: 1) it is more economical than one-on-one situations and, 2) participants can share experiences and thus gain from one another.

Context: This competency is employed across all agency contexts, with clients of all types and members of the community at large. Group settings are used when a need exists for a group of individuals to learn the same or related skills or knowledge. There are no particular time constraints other than those imposed by the group itself or by a treatment plan. Level: Technical and Associate-Professional.

Indicators:

1) Worker identifies the need(s) of a group to learn new skill(s) or knowledge or improve existing skills(s) or knowledge.

2) Worker develops a set of learning objectives related to the skill or knowledge need(s).

3) Worker develops a set of enabling objectives necessary for the learner's attainment to the learning objectives.

4) Worker selects or develops a learning strategy (process objectives) appropriate to the learners, their needs, the learning and enabling objectives, the existing resources and constraints, and his/her own style of facilitating learning.

5) Worker develops a plan for evaluating the learning experience.

6) Worker facilitates the group's objectives, acting as resource person, clarifier, gatekeeper, summarizer, etc.

7) The learner implements the chosen learning strategy. This strategy may involve:

   A) Didactic instructions;
   B) Structured tasks.

8) Worker evaluates the learning experience.

9) Worker discusses the results of the learning experience with learners, giving descriptive specific feedback and suggestions for future learning.

10) Worker records the results of the learning as appropriate and consistent with agency policy and procedures.

Competency Statement 29

MANAGING AND COMMUNICATING POLICY-RELATED DATA

Statement: Worker collects, records, and disseminates information in order to provide staff guidance and obtain monitoring, evaluation, and accountability feedback data for a treatment unit, treatment staff activities, and the operation of a physical facility.

Interpretation: This is a critical competency that relates to the information flow necessary for the smooth administration of a treatment program. The information and data pertain to treatment priorities, staff assignments, safety and physical comfort of staff and patients, the monitoring of supplies/equipment, and the maintenance of buildings and grounds.

Context: This competency might be carried out in any setting and with no particular time constraints other than efficiency, economy, and timeliness of activity. Generally, clients are not directly involved, however, clients or their representatives may provide input via such mechanisms as an advisory board, review council, etc.
Level: Associate-Professional.

Indicators:

1) Worker collects required data essential to efficient purchase and ordering of supplies and equipment for a defined period and unit maintains appropriate records.

2) Worker compiles and/or disseminates information related to safety, security, and emergency procedures to staff and clients and records reports of injuries and accidents to staff and patients.

3) Worker reviews staff assignments and records staff and unit activities in relation to treatment priorities for use in management of delivery services.

4) Worker collects client services outcome data and compiles periodic reports according to agency policies and guidelines.

5) Worker collects and records operational information, such as time records for payment of services, time studies, and other cost effective information, using established procedures.

6) Worker collects and verifies expenditures and posts financial entries to maintain and balance accounts.

7) Worker keeps records of data and information, prepares reports and processes them to supervisor and colleagues as required by organization policy and procedures.

Competency Statement 30

HOME VISITATION/FOLLOW-UP

Statement: Worker makes home visit to client in order to provide follow-up assistance and assurance that client receives necessary treatment and/or services in a safe and acceptable environment.

Interpretation: This is a critical competency in follow-up care to insure services are offered that match client's level of functioning and treatment needs. Home visit is possibly the primary source of supportive follow-up care with intent to negotiate with client the utilization of other treatment components available to him/her, such as community resources or sheltered workshop, etc. This competency is essential in providing case management of after-care services.

Context: This might be carried out from any setting and with any type of client but more likely from a community program where visitation is a part of the treatment plan. It could be a short-term plan but there are no specific time constraints except when client has not participated in necessary treatment, the visit should be made as close to the client lapse as is possible. Level: Technical and Associate-Professional. Visitation involving licensure-related inspection and reports would usually be at Associate-Professional level.

Indicators:

1) Worker pre-arranges and makes home visit to client in client's own community setting.

2) Worker initiates or continues facilitative (effective) relationship.

3) Worker greets client, explains purpose and objectives of visit and client's rights in order to facilitate flow of information and reduce client anxiety.

4) Worker maintains attentive behavior.

5) Worker "reads" and responds to "feeling tones" of client.

6) Worker uses language and expressions that client can understand.

7) Worker explains rationale, accurately outlines and identifies the choices, proposed activities, time and cost conditions, roles, expected outcome, and possible risks to client.

8) Worker elicits client's participation in the plan.

9) Worker obtains client's informed consent and commitment to an agreed-upon plan.

10) Worker informs client of probable future events and expectations and verifies client understanding.

11) Worker evaluates need and assists in providing necessary contingencies to plan, i.e., forms, transportation information, medications, etc.

12) Worker assesses client's ability and competency to maintain physical and medical self-care.

13) Worker evaluates or inspects environment to meet local or state health codes or pre-established standards for adequate environment and/or board.

14) Worker compiles and reports information to responsible monitoring group(s) or processes data to supervisor or colleague(s) as required by organization policies and procedures.

15) Worker identifies deficiencies in client health or environment.

16) Worker includes significant others in above transactions when appropriate.

17) Worker asks client and/or others for their understanding, clarifies if necessary, and closes interview.

Competency Statement 31

VOCATIONAL TRAINING AND JOB PLACEMENT

Statement: Worker assesses and trains clients in job-related skills, and places and monitors client's job functioning in order to enhance financial and emotional self-sufficiency and independence.

Interpretation: This is a frequent and important competency that enhances the self-worth and independence of the client through engagement in meaningful work. This competency is often critical to a client's treatment since vocational training is sometimes a criterion for client placement in halfway houses, night hospitals and similar supervised living programs. The competency may range from assuring the continuance of present employment to developing and coordinating a plan or carrying out segments that will lead client toward meaningful work.

Context: This competency might be carried out in all types of settings with all types of clients, with possible exceptions of the severely retarded or emotionally disabled. It frequently pertains to clients with no, or limited, salable skills as well as those whose prior job skills have deteriorated. The competency often is an essential part of physical rehabilitation programs. Time constraints may be imposed within structured training programs, however, in sheltered workshops, the training may be continuous. Limitations may be imposed by funding agencies or administrative restrictions. Level: Technical.

Indicators:

1) Worker receives or collects educational and vocational history.

2) Worker observes client for specific work habits or behavior, such as physical capacities, attention span, motivation, etc.

3) Worker administers or refers client for vocational-related testing: interest, aptitude, psychomotor and educational.

4) Worker initiates or continues a facilitative (effective) relationship.

5) Worker uses language and expressions that the client can understand.

6) Worker "reads and responds" to "feeling tones" of client.

7) Worker interviews client and elicits his participation in identifying preferences and establishing work goals.

8) Worker prepares a service plan related to work or preparation for employment and obtains client's specific consent and commitment to the plan.

9) Worker explains rationale, activities, choices, time and costs, roles and expected outcomes and possible risks to the client.

10) Worker performs or refers client to activities, sub-unit or groups consistent with plan, such as remotivation, teaching interviewing skills, grooming, increasing concentration, remedial education or academic program.

11) Worker performs or assures that client is exposed to appropriate modeling of job behavior.

12) Worker provides or arranges for client to receive essential job skills and work adaptive training or participation in graduated sheltered workshop system.

13) Worker monitors and evaluates client's level of work functioning (speed, concentration, safety, production) and instructs client when appropriate.

14) Worker develops and maintains job opportunities data and/or community group contacts for client employment (state employment agency and vocational rehabilitation agency, newspaper file, etc.).

15) Worker provides or arranges for on-the-job supervision or specific skill training when appropriate.

16) Worker informs client of workshop or setting's requirements for safety, payroll, dress, production, etc.

17) Worker assures that client is compensated appropriately.

18) Worker seeks job placement leads, discusses vacancies and client's job training with employers, and develops jobs for clients.

19) Worker monitors employment placement for client rights and local and federal standards for safe and satisfactory working conditions.

20) Worker informs client of possible future events and expectation and verifies client understanding.

21) Worker processes data to supervisor or colleague(s) as required by organizational policies and procedures.

Competency Statement 32

VIOLENT OR DESTRUCTIVE BEHAVIOR CONTROL

Statement: Worker prevents or controls violent or destructive behavior in order to protect client and others from harm.

Interpretation: This is a critical competency because the potential for violent or destructive acts exists at any time within a group of mental health clients. Anticipation of such potential behavior can provide the opportunity for therapeutic learning experience or the potential for reduction of future distractive behavior. A safe and calm therapeutic environment for clients is an essential first requirement.

Context: This competency is relevant to any client in any mental health setting. Anticipation and preventions are continuous. There are time constraints usually in that intervention action should take place immediately and remedial learning by client should closely follow the incident. Other constraints may depend on resources available and on policies and procedures of the organization. Level: Technical.

Indicators:

1) Worker observes and assesses potential for violence or destructive behavior.

2) Worker "reads" and responds to "feeling tones" of the client.

3) Worker maintains attentive behavior.

4) Worker attempts to prevent acute incidents by using assurance, a distracting activity, voluntary time out, and by controlling excessive stimulations and resulting conflicts immediately.

5) Worker takes appropriate action to intervene in incident--personal physical restraint or call for assistance (other staff, security guards, police) to restore calm, safe environment.

6) Worker recommends the action necessary to calm situation after the immediate crisis incident has terminated (use of restraints or medications, seclusion, formal charges, suspension, and restitution).

7) Worker explains rationale, identifies choices, proposed activity, time and cost conditions, expected outcomes, and possible risks to client.

8) Worker asks client for suggestions for his/her own participation in plan whenever possible.

9) Worker solicits information in a neutral and objective manner.

10) Worker informs client of probable future events and expectations, verifies client understanding.

11) Worker adheres to organization policy, Standard Operating Procedures or philosophy in dealing with critical incident.

12) Worker collects data on precipitants of critical incident.

13) Worker acts or consults with colleagues to eliminate precipitants of critical incident.

14) Worker processes data to supervisor or colleagues as required by organization policies and procedures.

Competency Statement 33

LIAISON

Statement: Worker provides inter- and intra-agency liaison in order to develop a complementary relationship or provide service program information to interested parties.

Interpretation: This is a frequent and critical competency necessary for providing linkage within a community and intergration of service delivery essential for continuity of care. The function involves providing information that serves to provide program visibility and foster effective public relations.

Context: The competency applies to all program elements and settings. Clients are generally not directly involved in the performance if the competency relationships are generally informal and ongoing. No time constraints apply although tour and visitations may be of limited duration. Available resources and distance may also limit personal visits and place emphasis upon telephone contact. Level: Technical and Associate-Professional. Initial inter-agency contact, development of agreements and understanding would generally be an Associate-Professional competency.

Indicators:

1) Worker plans, arranges, informs others, and guides visitation hours.

2) Worker keeps informed on internal and external program philosophy, eligibility, treatment, staffing and facilities including program limitations.

3) Worker provides information in friendly, discreet and responsive, but neutral and objective, manner.

4) Worker meets with representative of other units or other organizations prepared with detailed knowledge about needs, resources and concerns of clients or program he/she represents.

5) Worker maintains attentive behavior.

6) Worker seeks amelioration, compromise or consultation from colleagues to resolve conflicts or provide requested information.

7) Worker elicits information and encourages participation from other group(s).

8) Worker requests or receives information about programs of other agencies in order to understand agency and program.

9) Worker processes data to supervisor or colleague(s) as required by organization policies and procedures.

Competency Statement 34

LOGISTICS -- SUPPLIES AND EQUIPMENT

Statement: Worker orders, receives, distributes and accounts for equipment in order to manage resources.

Interpretation: This is a routine and frequently performed competency essential to efficient management of supplies and equipment, both purchased and donated. Supplies are those consumable materials needed for facility and environmental operation and maintenance and for program operation including therapeutic and recreational supplies, office supplies, and forms. Equipment includes non-expendable fixtures, furniture, machinery and vehicles. Accounting-for may be informal, by posting inventory recorded as to location, or formal, by assigning specific responsibility to a user or custodian.

Context: This competency applies to all workers in all settings. Safeguarding and cost-conscious use of agency or institution property and materials is an important responsibility of all workers at all levels. Assigned responsibility for maintaining and distributing appropriate quantities generally would be assigned to a Technical level worker. Similarly, maintaining accountability records would also be delegated to the Technical level human service worker or administrative/clerical personnel. The competency is at a relatively low level of difficulty and involves little complexity. There is generally no risk to clients except when clients are used to assist in movement or transport of equipment or supplies.

Indicators:

1) Worker obtains listings or requisition for needed equipment and supplies from users.

2) Worker receives listed requirements to assure complete identification and/or needed justification in accordance with organizational policy.

3) Worker establishes contract over ordering and receipt of consumable supplies, forms, etc., to assure their availability when needed.

4) Worker distributes equipment and supplies (including donated items) to the proper location.

5) Worker maintains formal or informal records (inventory) of non-expendable property in accordance with organizational policy and procedures.

6) Worker processes unsafe, broken, or inoperable equipment for repair, replacement or discard in accordance with organizational policy and procedures.

7) Worker applies safe practices in the lifting or movement of supplies by self or others in order to avoid injury or damage.

8) Worker processes unusual requests or occurrences to supervisor in accordance with organizational policies and procedures.

Competency Statement 35

STAFF SUPERVISION

Statement: Worker assigns work responsibilities, assesses individual's training and skills, identifies developmental needs, and plans and maintains a goal-oriented performance supervisory structure in order to achieve and maintain a high level of individual productivity and proficiency.

Interpretation: This is a frequently performed competency essential to achieving and maintaining a productive and harmonious level of staff functioning. Supervision may be formal, informal, or a combination of both. The supervisory responsibility envisioned here may be provided through a variety of methods but is usually structured and coordinated by one individual supervisor.

Context: This competency applies to all workers responsible for the performance of assigned staff (other staff members, trainees, volunteers, and students placed for experiential learning.) It applies in all settings and is continuous, in that advanced learning objectives are identified as former goals are obtained. Level characteristics: Associate-Professional.

Indicators:

1) Worker introduces self and identifies own role and work relationship.

2) Worker prepares, in advance, a job description which includes tasks, responsibilities and expectations for subordinate.

3) Worker orients subordinate to unit, clientele, work group, agency, and/or system where job is to be performed.

4) Worker explains to subordinates the personnel policies, practices, and procedures of unit, agency or system.

5) Worker orients subordinate to the legal implications of the prevailing mental health/retardation laws.

6) Worker discusses, reviews and assesses experience, skills, education, and training that subordinate brings to job in order to develop a performance plan.

7) Worker identifies area of training needed to:

   A) Perform job assignment;
   B) Develop special skills;
   C) Provide opportunity for increased responsibility or advancement.

8) Worker and subordinate jointly develop an individual performance plan to fulfill job assignment that recognizes current level of functioning while allowing for goal-oriented development.

9) Worker identifies priorities and weight factors as they relate to evaluation of performance.

10) Worker establishes the frequency and conditions of an ongoing, routine supervision schedule (i.e., weekly, monthly, individual, group, etc.).

11) Worker identifies the structure and format of supervision time (i.e., content, process, problem-solving, etc.).

12) Worker establishes criteria and conditions of supervision for special needs if indicated.

13) Worker prepares a written performance plan for joint signature and commitment which includes, but is not limited to, time elements, sequence goals, frequency and criteria for review.

14) Worker assigns tasks, work hours, and areas of responsibility in order to regulate staffing patterns.

15) Supervisor participates in direct observation, teaching, and problem-solving experiences in order to facilitate staff development.

16) Worker counsels and is resource for ongoing learning of personnel, legal agency, and other policies and procedures.

17) Worker provides or assists subordinate in identifying and obtaining learning resources, continuing education, or skill specialization training.

18) Worker interprets training, behavior, attitudes, etc. into service delivery routine.

19) Worker provides opportunity and counseling for early problem identification and resolution.

20) Worker clearly identifies structure and expectations for corrective action.

21) Worker counsels or refers employee with personal, family, health or attitudinal problems affecting his/her job performance in order to restore job functioning.

22) Worker encourages initiative, problem identification, new ideas and constructive interpersonal relationships in job functioning.

23) Worker counsels subordinate to identify long-term career goals and developmental opportunities and encourages progress towards those goals.

24) Worker assigns new tasks or responsibilities as indicated by either process of personal development or as job requirements and/or functions are modified or change.

25) Worker gathers and coordinates ongoing information and observations from peer groups, co-workers, professional staff, agency, and community contacts regarding subordinate's performance and attitude in order to facilitate, broaden and enhance the supervisory process.

26) Worker quizzes, examines, and critiques performance, provides feedback and offers constructive suggestions for further development or attainment of performance goals.

27) Worker records and provides written evaluation and summary of performance (which may include goal attainment, adherence to personnel rules, interpersonal work relationships, etc.) according to organizational policies and procedures.

Competency Statement 36

PERSONNEL FUNCTIONS: RECRUITMENT/SELECTION

Statement: Worker recruits, selects and/or evaluates job applicants, volunteers, or trainees in order to obtain efficient human resources on behalf of agency or work unit.

Interpretation: This is an essential and continuous competency relating to the formally and informally designed duties of recruitment, selection and evaluation of subordinates, volunteers and students. The continual need for skilled human resources in mental health necessitates competency in acquiring efficient workers consistent with the priorities and goals of the work unit.

Context: This competency is necessary for all workers and all agencies with a designated responsibility for selection and utilization of personnel. Although the selection of personnel may take more than a single session, there would be limited contacts. Level characteristics: Associate-Professional.

Indicators:

1) Worker knows agency or unit personnel policies and pertinent rules governing employment or use of volunteers.

2) Worker knows and adheres to Equal Employment Opportunity guidelines.

3) Worker follows agency's affirmative action plan.

4) Worker collects information about proposed worker's role, hours, agency, and/or unit expectations and salary.

5) Worker writes advertisement and/or job description using the channels for recruitment that are sanctioned by agency.

6) Worker checks references and assesses application or information from applicant, measuring qualifications against established criteria for a particular job.

7) Worker interviews, or causes to be interviewed, qualified applicants using defined and pertinent interview questions and techniques.

8) Worker orients and introduces potential worker to:

   A) Agency purpose or philosophy;
   B) Supervisors;
   C) Physical facilities;
   D) Expectations of role;
   E) Work unit orientation schedule;
   F) Personnel policies and procedures essential to potential employee;
   G) Confidentiality laws and procedures.

9) Worker processes data and/or recommendations to supervisor, personnel office or colleagues as required by organization policies and procedures.

Competency Statement 37

PERSONNEL FUNCTIONS: EMPLOYEE RELATIONS

Statement: Worker investigates, mediates, or arbitrates conflicts or grievances between workers and/or union and/or employer representative in order to resolve conflicts or grievances or to improve working relationships and solve employment problems.

Interpretation: This is an essential and continuous competency that is a role expectation for all supervisors. Harmonious interpersonal staff relationships are considered essential to staff efficiency and high morale.

Context: This competency would apply in any employment setting where the competency is an informal personnel administrative function of all supervisors (i.e., agencies not having an employment relations staff specialist within the personnel office). Level: Associate-Professional.

Indicators:

1) Worker knows and adheres to agency and work unit personnel policies, Equal Employment Opportunity guidelines and grievances procedures, and agency's affirmative action plan.

2) Worker knows provisions of union contract (where applicable).

3) Worker collects data about circumstances of difficulty or grievance and/or interviews parties involved.

4) Worker mediates and/or proposes solution or remediation.

5) Worker proposes actions for prevention of future related or similar problems.

6) Worker processes data to supervisor and/or colleagues according to agency policy and procedures.

Competency Statement 38

RESEARCH/EVALUATION

Statement: Worker identifies need, plans and conducts research or evaluation in order to provide information for program management, planning or reporting.

Interpretation: This competency may be performed in a continuous or intermittent manner to provide essential information for administrative decision-making concerning quality, availability of programs, cost effectiveness, organizational development, compliance with federal mandates and/or preparation of reports to funding or other groups.

It may also be a one-time activity to collect "hard" research data for a specific goal. Both applications of the competency require the use of similar technical skills. Additionally, ongoing evaluation requires highly developed interpersonal skills. The technical skills of statistical analysis, computer technology, data management or cost accounting may apply to both applications.

Context: Evaluation in some form is essential in all service programs, both institutional and community-based, in order to provide efficient service to clients and to enhance sound management practices. Competency in evaluation and research is not likely to be totally embodied in one person, but may be dispersed within an agency or program or among persons designated as an evaluation team with specific duties assigned to each individual to meet a variety of goals and needs. It may be carried out among both givers and receivers of services depending on the specific aim of the evaluation study and, therefore, benefits both groups. Level: Technical and Associate-Professional. At the Technical level the competency would most likely involve data gathering and compilation and some limited report writing. Research design, statistical analysis, interpretation, recommending action to management and professional publications would be at the Associate-Professional level or under the direct supervision of a research specialist.

Indicators:

1) Worker identifies evaluation/research need or assignment to include goal, objective(s) and outcome expectations.

2) Worker identifies needed resources and arranges for their use.

3) Worker prepares self with appropriate knowledge/skills essential to a particular research/evaluation assignment through literature search or consultancy to include:

   A) Program evaluation techniques;
   B) Management procedures;
   C) Funding, cost accounting and reimbursement;
   D) Clinical procedures;
   E) Experimental research design;
   F) Statistical and computer technology;
   G) Data analysis and use of information.

4) Worker establishes criteria for research/evaluation design to include:

   A) Hypothesis or outcome measure;
   B) Schedule;
   C) Subjects or target group;
   D) Delimitation;
   E) Analysis methodology.

5) Worker plans/outlines step-by-step procedures for conducting evaluation/research.

6) Worker seeks approval for proposal and procedures from technical consultant and/or authorized administrator.

7) Worker informs staff of study objectives, methodology and procedures, and elicits feedback from supervisor and colleagues.

8) Worker establishes and maintains a non-threatening collaborative and objective relationship with management and participant groups involved in evaluation study.

9) Worker collects data using methodology appropriate to the research/ evaluation design.

10) Worker analyzes data with respect to criteria.

11) Worker evaluates data for modification of design or continued monitoring.

12) Worker processes data and/or makes recommendations to supervisor or management as required by evaluation/research design and organizational policies and procedures.

13) Worker provides feedback about outcomes to interested groups.

14) Worker suggests other special evaluation needs that may have surfaced during the evaluation.

15) Worker proposes publication of significant findings.

Competency Statement 39

PROVIDING INFORMATION IN WRITTEN FORM

Statement: Worker provides information in written form in order to create a durable record of work-related observation, impressions, decisions, plans or recommendations.

Interpretation: This is an essential and frequent competence which applies to any worker who, at any time, prepares a written record of work-related experiences.

Context: The context in which this competence is employed, as well as the kinds of experiences to be recorded, determine the complexity of the competency. This will vary with contexts, settings, assignments, and individual workers. The experiences recorded may be in the form of worker observations or impressions of client behavior or worker behavior, plans the worker has designed, questions the worker has asked to acquire information, etc. Level: Technical and Associate-Professional. This competency is a component of many other competence statements.

Indicators:

1) Recognizes situations in which it is appropriate to record information in written form.

2) Follows written format required by agency or selects one appropriate to the situation in which the recorded information will be used.

3) Selects a written style that is appropriate to the characteristics of the individual(s) or agency who will use the written record.

4) Seeks assistance in composing written records when needed.

5) Selects appropriate information for recording.

6) Organizes information for presentation in a logical sequence.

7) Uses correct grammar, punctuation, spelling.

8) Records information legibly, in selected format and style, consistent with agency policies, and in compliance with legal/ethical requirements for confidentiality.

9) Worker processes record to supervisor or others as required by organization policies and procedures.

Competency Statement 40

OBTAINING INFORMATION FROM RECORDED MATERIALS

Statement: Worker obtains information from recorded materials in order to have information available for making work-related decisions, plans or recommendations.

Interpretation: This is an essential and frequent competency which applies to any worker who, at any time, is expected as part of his/her job responsibilities to read, understand, and/or comply with the content of recorded materials.

Context: This competency is employed when reading reports, records, directives, regulations, files, notes, manuals, instructional materials, etc., or listening to audio tapes. The level of complexity required in employing the competency varies in relation to the level of complexity of the work-related judgments and decisions the worker is expected to make and to the complexity and/or difficulty of the resource material. Level: Technical and Associate-Professional. The competency is a component of many other competencies.

Indicators:

1) Recognizes situations in which it is appropriate to obtain information from recorded materials.

2) Knows sources for and obtains recorded materials in a manner consistent with agency policies and procedures and maintains confidentiality.

3) Recognizes appropriate information in the materials obtained.

4) Acquires assistance in interpreting information as necessary.

5) Assimilates the essence of the information's content and notes source for future utility.

APPENDIX 2

PARTICIPANTS

The following persons served as members of the various task forces that advised the project, helped in the development of competency statements and reviewed the work.

Harriet Andrews
1201 Purdy Court
Lutherville, Maryland 21093

Betty Baer, Director
Undergraduate Social Work Curriculum
710 Allen Hall
School of Social Work
West Virginia University
Morgantown, West Virginia 26506

Margaret Bell
Route 1, Wakefield Circle
Kendellville, Indiana 46755

Roger Betz
Inver Hills Community College
8445 College Trail
Inver Grove Heights, Minnesota 55075

Yvonne Brooks
Mental Health/Human Services
Georgia College
Milledgeville, Georgia 31061

F. Coit Butler
College of Public and Community Service
University of Massachusetts
Boston, Massachusetts 02125

Shirley Clayton
Fort Logan Mental Health Center
3520 West Oxford Avenue
Denver, Colorado 80223

Miriam Clubok
Ohio University
214 Morton Hall
Athens, Ohio 45701

Mary Lou Cormier
Bangor Community College of the
University of Maine at Orono
Bangor, Maine 04401

Kenneth Cox
3101 Fairmont Lane
Pueblo, Colorado 81008

Baudouin de Marcken, Project Coordinator
Skills Matrix Project
Medical College of Pennsylvania
107 Forest Avenue
Narberth, Pennsylvania 19072

Mary DiGiovanni
Northern Essex Community College
100 Elliot Street
Haverhill, Massachusetts 01810

Maria Duncan, Director
Substance Abuse Counselor Training
Program
Santa Fe Community College
Gainesville, Florida 32601

John Fauser, Director
Department of Health Manpower
American Medical Association
535 North Dearborn Street
Chicago, Illinois 60610

Donald L. Fisher, Section Chief
Paraprofessional Manpower
Development Branch
National Institute of Mental
Health
5600 Fishers Lane
Rockville, Maryland 20857

Helene Gerstein, Director
Community College of Philadelphia
Competency Board
Mental Health/Social Service
Curriculum Project
Community College of Philadelphia
34 South 11th Street, Room 843
Philadelphia, Pennsylvania 19107

William Grimm
1127 - 11th Street, Main Floor
Sacramento, California 95814

Lorraine Hagar
Fort Logan Mental Health Center
3520 West Oxford Avenue
Denver, Colorado 80223

Roosevelt Harmon, Jr.
J. Sargeant Reynolds Community
College
108 East Grace Street
Richmond, Virginia 23230

Peggy Heaps
1115 Arran Road
Baltimore, Maryland 21239

William Holtcamp
Route 6, Box 748
Waco, Texas 76706

Angela Holweger
Research Coordinator
South Carolina Paraprofessional
Career Development Program
South Carolina Department of
Mental Health
P. O. Box 485
Columbia, South Carolina 29202

Vernon James
Division of Manpower and Training Programs
Paraprofessional Manpower Development Branch
National Institute of Mental Health
5600 Fishers Lane
Rockville, Maryland 20852

Shirley Kotek
Route 2
Averill Park, New York 12018

Elise Labe
New Careers Project
Central State Hospital
P. O. Box 4030
Petersburg, Virginia 23803

Donald Lake, Program Administrator
South Carolina Paraprofessional Career
Development Program
South Carolina Department of Mental Health
P. O. Box 485
Columbia, South Carolina 29202

Corrine W. Larson, Director
Division of Health Manpower
Minnesota Department of Health
717 Delaware Street, SE, Room 345
Minneapolis, Minnesota 55440

Jim Mahanes, Director
Department of Human Services
Jefferson Community College
Louisville, Kentucky 40201

Albert Maslow
Educational Testing Service
Princeton, New Jersey 08540

Rebecca L. Maze
Psychological Learning Center
Admissions Building
Bryce State Hospital #3
Tuscaloosa, Alabama 35401

James D. McKeel
Floyd Junior College
P. O. Box 1864
Rome, Georgia 30161

Lenore Whitman McNeer
Vermont College
Montpelier, Vermont 05602

Dennis Montgomery
Route 2, Box 398
Cass Lake, Minnesota 56633

Jan Monti, Director
Human Services Training Institute
327 West Eighth Street, Suite 120
Spokane, Washington 99204

Mary D. Moore
Regional Director, Division of Mental Health
State of North Carolina
225 Green Street, Suite 504
Fayetteville, North Carolina 28302

Teresa Nieberding
3763 Marburg, Apt. 4
Cincinnati, Ohio 45209

Thomas Noel
13900 East Harvey Lane
Lodi, California 95240

Paul Pottinger
National Center for the Study of the Professions
1527 New Hampshire Avenue, NW
Washington, D. C. 20036

David Richards
Department of Psychology
John Tyler Community College
Chester, Virginia 23831

Cleta Rudolph
979 Pierce Avenue
Columbus, Ohio 43227

Robert Siegfried
Program Director, Skills Matrix Project
Medical College of Pennsylvania
107 Forest Avenue
Narberth, Pennsylvania 19702

Arthur L. Slater, Director
Career Education for Mental Health Workers
Human Resources Institute
University of South Florida
Tampa, Florida 33620

Steven C. Smith
1124 Oswego Road
Sumter, South Carolina 29150

Dorothy Sparer, Writer
Editorial Services
337 South Milledge
220 Butler Building
Athens, Georgia 30605

Jean Steffan
Community Mental Health Center Worker
Cincinnati, Ohio 45220

Mae Steven
Stanford Research Institute International
Menlo Park, California 94025

Pam Stoll
4005 Granada
Tampa, Florida 33609

Julia N. Stork, Coordinator
Jefferson State Junior College
2601 Carson Road
Birmingham, Alabama 35215

Stephen C. Sunderland, Dean
College for Human Services
201 Varick Street
New York, New York 10014

Robert J. Teare
Director of Research
School of Social Work
University of Alabama
P. O. Box 1935
University, Alabama 35486

Stephen W. Wells, Director
Center for Human Potential
164 Division Street, Suite 401
Elgin, Illinois 60120

Larry Whitlock
Western Piedmont Community College
Morganton, North Carolina 28665

Tom Wisbey
North Shore Community College
3 Essex Street
Beverly, Massachusetts 01915

George Ziener, Education Administrator
Manpower and Training Branch
Division Resource Development
National Institute of Drug Abuse
11400 Rockville Pike
Rockville, Maryland 20857

Other Consultants

Dean Elias
Antioch College/West
1729 - 17th Street
Seattle, Washington 98122

Kenneth Finger
College of Pharmacy
University of Florida
Gainesville, Florida 32610

SREB Staff

Arthur L. Benton
Project Director
Paraprofessional Worker
Certification Project

Harold L. McPheeters
Director, Commission on Mental
Health and Human Services

Edward J. Jacobs
Project Director
Program Approval Project

Appendix 3

JOB ANALYSIS SURVEY

for use by the
PARAPROFESSIONAL-WORKER CERTIFICATION PROJECT
SOUTHERN REGIONAL EDUCATION BOARD
130 Sixth Street, N.W.
Atlanta, Georgia 30313
Project # 1 T41 MH 14520 MHST

Arthur L. Benton, Ph.D.
Project Director

March 1978

DISCLAIMER: Any reports that are developed from the information on this survey will not reveal the identity of any respondent. Any item (including your name) may be omitted.

This questionnaire is designed to provide up-to-date information about your job activities. Properly answered, it should reflect what you are doing in your present job and will help the Southern Regional Education Board and the National Institute of Mental Health develop a competency performance certification system for mental health/human service workers.

This questionnaire has five parts. PART I requests that you describe how frequently you carry out specific tasks. PART II requests that you identify other tasks that you do which were not included in the task clusters in PART I. PART II involves indicating how much of your working time is divided among a group of 14 task clusters; each cluster is identified and defined for you. PART IV asks for information about how you get your instructions. PART V requests some personal information.

READ OVER EACH PART ENTIRELY before answering any of the questions. Feel free to question the survey monitor about definitions or any items that are not clear.

PART I FREQUENCY OF ACTIVITY

In this part of the SURVEY you will find a series of tasks which are grouped under general clusters. For each of the tasks, we are interested in finding out how often you do the task. To answer this question, we will use a code to reflect how often you do a particular task. It is pictured below in the form of a scale:

I PERFORM THIS TASK:

Never	Seldom	As Often As Not	Very Often	Always
[1]	[2]	[3]	[4]	[5]

To the left of each task statement there is a column of boxes. The answers to PART I are to be entered in the box next to the task statement. Simply choose the number from the scale above that best describes how often you do the task (in the course of a normal month) and enter that number in the box next to the task question. For example, if you never carry out a particular task, you would put a "1" in the box. If you do the task very often, you would put a "4" in the box, and so forth. COMPLETE ALL OF PART I BEFORE GOING ON TO PART II.

NOTE: "Always" means very, very often. It should be used for a task which you do a great number of times during a typical work period.

TASKS RELATED TO BROKERING

/ / 1. Arrange transportation for client with appropriate person/agency, using telephone or routine referral procedures--in order to provide transportation for client to service or treatment resource.

/ / 2. Advise service client regarding anticipated service events or specific community resources--in order to prepare client for the service event.

/ / 3. Inform person of services and/or locations of specific community resources--in order to promote utilization of appropriate resources.

/ / 4. Prepare letter, memorandum, or standard referral form, using knowledge of client situation and service delivery system--in order to link a client with an appropriate service resource.

/ / 5. Discuss client situation with service representative (including relation or potential employer), request a commitment of assistance--in order to arrange for specific services.

/ / 6. Inform client of appointment between client (or relation) and worker or other service delivery person, using telephone, letter, home visit, or public address system--in order to schedule or remind client of previously scheduled appointment.

/ / 7. Read classified advertisements and other job leads and discuss positions and vacancies with employers--in order to develop jobs for service clients.

/ / 8. Explain program, policy, or procedural matters to client, relation, or call-in who requests general program-related information--in order to interpret agency operations or procedures.

/ / 9. Prepare appropriate forms to admit client for treatment or to obtain benefits for client.

.....GO ON TO PAGE 3 FOR NEXT CLUSTER: CLIENT ADVOCATING

NOTE: FINISH ALL CLUSTERS IN PART I BEFORE PROCEEDING TO PART II.

PART II ADDITIONAL TASKS

The listings of tasks in PART I were obtained from job analysis conducted within a wide range of human services programs in many different states. The lists have been shortened to make it easier for you to answer the questions posed. However, we need to know if you do other tasks which have not been included. At the end of each cluster of the tasks in PART I we have left spaces for you to add other tasks related to that cluster which you carry out. Write all additional tasks using a format similar to those tasks in PART I, i.e., what is done, how, to and for whom, and for what purpose. Please indicate the frequency for any added tasks in the same manner as you did in PART I.

ADDITIONAL TASKS RELATED TO BROKERING

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.....GO ON TO PART II, PAGE 3.

PART I (con't)

TASKS RELATED TO CLIENT ADVOCATING

/ / 1. Confer with service system colleagues, review service for specific action in process--in order to influence more favorable decision for the client.

/ / 2. Discuss client's needs with relations or third-parties, such as landlords, employers, merchants, etc.--in order to bring about favorable action for the client.

/ / 3. Intervene in problem situation between clients or between client and agency representative or vendor, clarify issues--in order to derive satisfactory solution.

/ / 4. Review treatment plan and procedures--in order to assure that client's human rights are maintained.

/ / 5. Assist client who has been denied service to obtain supportive documentation, such as birth or naturalization records, social security numbers, etc.--in order to establish client's eligibility for services.

/ / 6. Permit access to client information only to authorized and appropriate persons--in order to protect the client's rights to privacy and confidentiality.

.....GO ON TO PAGE 4 FOR NEXT CLUSTER: ACTIVATING

PART II (con't)

ADDITIONAL TASKS RELATED TO CLIENT ADVOCATING

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.....GO ON TO PART II, PAGE 4

PART I (con't)

TASKS RELATED TO ACTIVATING

/ / 1. Plan details of new service program, occasionally with others--in order to develop program proposals.

/ / 2. Discuss service programs with potential providers--in order to develop provider such as sponser, volunteer, etc.

/ / 3. Discuss plans for non-existent services with service system colleague, agency official, or local citizen, encourage support of plan—in order to develop support for new services.

/ / 4. Describe unmet service needs and a proposed plan to legislators or other official--in order to obtain legislative support.

.....GO ON TO NEXT CLUSTER BELOW: SYSTEMS ADVOCATING

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TASKS RELATED TO PROBLEM SOLVING

/ / 1. Discuss/explain over payment with client, request information when needed, using personal visit, telephone, or written correspondence—in order to plan repayment.

/ / 2. Advise client using telephone, personal visit, or written correspondence--in order to motivate client to follow through on referral or to return to treatment.

/ / 3. Counsel/talk with client or relative, prevent undesirable behavior when necessary--in order to motivate acceptable/responsible behavior (aspects of social control, i.e., family planning, runaway prevention, etc.)

/ / 4. Inform client of the results of medically-related tests or problems, explain implications--in order to calm client (soothe fears, release anxiety, reassure, support) and discuss or explore indicated follow-up.

/ / 5. Talk to client or relation, explore problems, answer questions when necessary in order to calm client (soothe fears, release anxiety, reassure, support).

/ / 6. Discuss aspect of administration of treatment or treatment plan or rpogram with client and/or relations, inform, clarify, brief, or answer questions--in order to promote understanding or soothe fears.

/ / 7. Counsel with client regarding undefined personal problems, define needs, articulate problems, and answer questions--in order to resolve problems or begin resolution of problems.

/ / 8. Explain rules or program or agreement to client (often new), answer questions when asked--in order to orient or re-orient client to a particular program.

/ / 9. Counsel client who is discharged from treatment--in order to assure client of availability of post-discharge services.

/ / 10. Make home visit to client who does not respond to follow-up contact by phone, analyze problem, explore alternatives, and negotiate with client--in order to insure client receives needed treatment.

.....GO ON TO PAGE 6 FOR NEXT CLUSTER: SKILL BUILDING

PART II (con't)

ADDITIONAL TASKS RELATED TO PROBLEM SOLVING

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.....GO ON TO PART II, PAGE 6

PART I (con't)

TASKS RELATED TO SKILL BUILDING

/ / 1. Teach crafts, provide therapy for clients that enables them to make some things for themselves they might not otherwise be able to have, using raw materials and tools appropriate to specific craft--in order to teach manual skills.

/ / 2. Train client in mealtime self-help skills (food preparation, eating, decorum, cleanup, etc.)--in order to develop independent mealtime skills.

/ / 3. Train client to brush his/her teeth and wash and bathe--in order to develop independent hygiene skills.

/ / 4. Train client in personal grooming and dressing--in order to develop independent self-care skills.

/ / 5. Teach client skills relating to money, such as recognition, budgeting, etc., using learning programs when appropriate--in order to develop concepts of money and money management.

/ / 6. Teach client personal mobility skills, accompany client on routine excursions when appropriate--in order to develop independent functioning.

/ / 7. Teach clients in a small group or during structured activity, such as leisure, social, or physical activities, using learning programs when appropriate--in order to develop basic socialization or independent skills.

/ / 8. Supervise client's work or chores, instruct client in methods or procedures when appropriate--in order to promote effective work habits.

/ / 9. Train client in toileting routines, awake and/or usher to toilet when necessary--in order to develop elimination control and comfort.

/ / 10. Counsel parents or foster parents regarding children, using knowledge of human behavior and child management techniques, advise them when indicated--in order to communicate specific techniques.

.....GO ON TO PAGE 7 FOR NEXT CLUSTER: CONSULTING

PART II (con't)

ADDITIONAL TASKS RELATED TO SKILL BUILDING

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.....GO ON TO PART II, PAGE 7

115

PART I (con't)

TASKS RELATED TO CONSULTING

/ / 1. Consult service system colleagues regarding case situation, inform them of case details--in order to solicit direction/instruction in dealing with case situation.

/ / 2. Review case with colleagues, clarify, interpret, and evaluate case situation, recommend methods--in order to instruct colleagues in dealing with case situation.

/ / 3. Confer with colleagues, receive help, instruction, or interpretation--in order to learn methods, procedures, policies, assignments, etc.

/ / 4. Review procedures or policy or law with colleagues, answer questions when asked--in order to inform colleagues in new or established routine or nature of policy.

/ / 5. Discuss client's situation with service system colleagues, state officers, legislative officials, or judges--in order to exchange information useful in service planning or service provision.

/ / 6. Reuqest/receive clarification of specific operational information from service system colleagues--in order to learn the nature of particular services or policy or procedure.

/ / 7. Discuss program activity with colleagues or supervisors--in order to inform them of administrative events/status.

/ / 8. Discuss community (internal/external) activity with client group, using knowledge of treatment programs--in order to assist clients in planning.

/ / 9. Advise administrators/colleagues about details of grant application--in order to supply technical assistance.

/ / 10. Consult with colleagues regarding professional knowledge, technique, or skill--in order to instruct them in particular or appropriate methods.

.....GO ON TO PAGE 8 FOR NEXT CLUSTER: TEACHING

PART II (con't)

ADDITIONAL TASKS RELATED TO CONSULTING

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.....GO ON TO PART II, PAGE 8

PART I (con't)

TASKS RELATED TO TEACHING

/ / 1. Tutor individual trainees/employees in job-related skills or procedures, help them with assignment when indicated--in order to instruct them in job-related functions or on-job training.

/ / 2. Teach target group of trainees, employees, or students specific subject matter, in classroom or laboratory setting, according to training plan, using handout material or visual aids, and inform individuals of program-related concerns--in order to provide specific information to group or to increase knowledge or skills of staff.

/ / 3. Evaluate results of training session, such as quiz, verbal feedback, or video tape--in order to determine the effectiveness of and future direction of program.

/ / 4. Plan training program or package, occassionally with service system colleagues, design curriculum, schedule instructional periods, etc.-- in order to develop training programs.

/ / 5. Administer appropriate tests to trainees--in order to assess progress in training program.

/ / 6. Diagnose training needs in relation to job expectations of employees-- in order to plan individualized training program.

/ / 7. Learn external agency program while on tour with agency representative, ask question--in order to develop understanding of program.

/ / 8. Attend training session, such as class, workshop, institute, presentation, drill, etc.--in order to learn skills, methods, knowledge, or procedures.

/ / 9. Attend regularly scheduled workshop ("feedback") with colleagues, discuss events of the day, problems or interaction with particular clients-- in order to develop knowledge of program operations and individual clients.

/ / 10. Study professional literature, such as reports, policy manuals, journals, training materials, etc.--in order to improve professional knowledge.

.....GO ON TO PAGE 9 FOR NEXT CLUSTER: REMEDIATION

PART II (con't)

ADDITIONAL TASKS RELATED TO TEACHING

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.....GO ON TO PART II, PAGE 9

117

PART I (con't)

TASKS RELATED TO REMEDIATION

/ / 1. Use passes, phone calls, etc., as positive or negative reinforcement--in order to change client's behavior.

/ / 2. Encourage client's preceptions of reality by explaining behavior of others, (by demonstrating that client's food is not poisoned, etc.)--in order to reduce in appropriate behavior.

/ / 3. Supervise client on withdrawal therapy--in order to monitor treatment.

/ / 4. Reinforce client's positive behavior--in order to increase frequency of appropriate behavior.

/ / 5. Determine baseline for maladaptive behaviors, plan and implement behavior modification treatment programs--in order to extinguish or modify maladaptive behaviors.

/ / 6. Coordinate families' and friends' visits with treatment plan--in order to provide and improve socialization and family relations.

/ / 7. Counsel clients in group therapy session, using knowledge of group processes and group rehabilitative methods--in order to develop independent behavioral functioning.

/ / 8. Counsel client and/or family member, using recognized intervention methods and operational knowledge of particular agencies, advise them of consequences when appropriate--in order to improve social functioning and/or reconcile family relations.

/ / 9. Conduct therapeutic activity for client group, occasionally with colleagues--in order to meet treatment objectives.

/ / 10. Conduct/participate in group meetings, such as house meetings, ward meetings, peer courts, etc., using knowledge of group techniques, solve immediate problems--in order to improve functioning of residential community or improve individual behavior.

.....GO ON TO PAGE 10 FOR NEXT CLUSTER: PERSONAL CARE GIVING

PART II (con't)

ADDITIONAL TASKS RELATED TO REMEDIATION

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.....GO ON TO PART II, PAGE 10

PART I (con't)

TASKS RELATED TO PERSONAL CAREGIVING

/ / 1. Structure the client's day--in order to maintain the physical and emotional well-being of the individual.

/ / 2. Supervise client's use of cosmetics--in order to contribute to grooming of client and avoid hazards.

/ / 3. Observe client for clues to possible impending deviant or disruptive behavior or escape--in order to provide alternative activity or prevent elopement.

/ / 4. Control client without harm to self or others--in order to maintain physical well-being.

/ / 5. Orient client or new staff to residential or day-care facility, acquaint newcomer with staff and clients, the physical facility, and the unit procedures--in order to provide familiarity with environment and expectations.

/ / 6. Perform body checks for scars, bruises, etc., and provide first aid to client when required, within limits of policy and law--in order to maintain physical well-being.

/ / 7. Obtain vital signs and observe for physical manifestations of emergency condition, such as seizures, tremors, paralysis, memory defects, cardiovascular accidents, heart attack, etc.--in order to obtain appropriate treatment.

/ / 8. Observe client for side effects of medication--in order to obtain appropriate treatment or change of medication.

/ / 9. Plan and when appropriate, participate with client in exercise activity, conversation, or recreation--in order to establish rapport, exercise, or socialize client.

/ / 10. Escort client to internal and external locations--in order to assure safe arrival to and from schedules services or activities.

.....GO ON TO PAGE 11 FOR NEXT CLUSTER: MILIEU MANAGEMENT

PART II (con't)

ADDITIONAL TASKS RELATED TO PERSONAL CAREGIVING

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.....GO ON TO PART II, PAGE 11

119

PART I (con't)

TASKS RELATED TO MILIEU MANAGEMENT

/ / 1. Restrain violent or destructive client when necessary--in order to reduce danger to self and others and to maintain safe, orderly environment.

/ / 2. Monitor client having history of violent, destructive, or combatant behaviors--in order to assure safe and secure environment.

/ / 3. Monitor client locked in quiet rooms when necessary--in order to comfort and provide security for client.

/ / 4. Identify, reduce, or eliminate excessive stimulation in client's environment--in order to maintain tranquil state.

/ / 5. Intervene by counseling warning, or separating clients in dispute--in order to maintain order.

/ / 6. Assist client in making temporary or permanent decorations for facility--in order to provide a pleasant and appropriate atmosphere.

/ / 7. Monitor client who has a history of taking dangerous objects--in order to provide a safe environment.

/ / 8. Monitor client locked in quiet room to detect and provide for physical needs--in order to maintain acceptable level of functioning.

.....GO ON TO PAGE 12 FOR NEXT CLUSTER: CASE MANAGEMENT

PART II (con't)

ADDITIONAL TASKS RELATED TO MILIEU MANAGEMENT

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.....GO ON TO PART II, PAGE 12

PART I (con't)

TASKS RELATED TO CASE MANAGEMENT

/ / 1. Present intake and social history data on client interviewed--in order to provide information for treatment disposition decisions.

/ / 2. Identify and develop specific treatment plan, consider capacity and limitations of client as well as those of staff and institution--in order to develop treatment plan.

/ / 3. Confer with colleagues in team, court unit, or committee staff meetings--in order to reach consensus in regard to the disposition of specific case.

/ / 4. Present case or provide information and opinion concerning client at staff meetings--in order to monitor and evaluate progress, modify treatment plan, or to terminate treatment.

/ / 5. Review file or record with client and/or relative, evaluate present status or progress, discuss situation when appropriate--in order to recommend continuation, modification, or termination of treatment.

/ / 6. Conduct discharge assessment--in order to recommend discharge, termination, or continuation of treatment.

/ / 7. Evaluate written or personal referral received from service system colleague or citizen, clarify basic information, use knowledge of programs--in order to accept referral and intiate service action according to established policies or advise client of alternate sources.

/ / 8. Confer with service system colleagues on specific cases, or specific client groups, reach mutual agreement on details of services/case actions and staff responsibilities--in order to coordinate or implement services.

/ / 9. Discuss case situation with client and/or relative, plan alternate care for client, such as foster home, return to home, home visit, respite care, hospitalization, etc.--in order to arrange suitable or appropriate environment.

/ / 10. Review case records, staff workload, and staff capabilities--in order to assign case to unit staff for treatment and/or follow-up.

.....GO ON TO PAGE 13 FOR NEXT CLUSTER: DATA HANDLING

PART II (con't)

ADDITIONAL TASKS RELATED TO CASE MANAGEMENT

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.....GO ON TO PART II, PAGE 14

PART I (con't)

TASKS RELATED TO DATA HANDLING

Client Data

/ / 1. Observe for and record signs of grief/mourning, suicide, or crisis potential, through processes, reality orientation, social skills, etc.--in order to provide information for evaluator and treatment planning.

/ / 2. Administer objective and projective psychological tests--in order to provide diagnostic information for evaluation and treatment planning.

/ / 3. Record/dictate case information, such as daily observations, case narratives, etc., update case files or notebook, provide case status information, such as opened, closed, transferred, etc.--in order to provide record of services.

/ / 4. Prepare social and work history from information obtained from client, relative, or other record--in order to provide information for intake treatment planning, or case review.

/ / 5. Review case information or service request analyze necessary information in order to determine eligibility or adjust benefits.

/ / 6. Prepare and/or respond to correspondence--in order to obtain or provide referral information.

Systems Data

/ / 7. Maintain records of daily unit staff activities--in order to provide information for monitoring unit or program.

/ / 8. Record information about injuries and accidents to clients amd staff--in order to compile information for evaluating institutional operations and other reports.

/ / 9. Record information about services provided to clients, according to established policies--in order to provide record of services provided for periodic reports.

/ / 10. Collect/record operational information using standard form or standardized methods of work sample, time study, etc.--in order to provide for payment analysis, etc.

/ / 11. Collect status information relating to condition of building, inventories of building contents, and needed repairs, etc.--in order to record information for periodic report.

/ / 12. Verify expenditures and post financial entries--in order to record expenditures and balance accounts.

Staff Data

/ / 13. Record personal activities, such as travel, time cards, etc., using standard reporting form--in order to summarize items for reimbursement.

/ / 14. Record staff (including paid clients) information, such as attendance, leave, training, etc.--in order to provide information for payroll and fiscal control.

.....GO ON TO PAGE 14

PART I (con't)

TASKS RELATED TO DATA HANDLING (con't)

Research Data

/ / 15. Survey specific population by mail, telephone, or in person--in order to collect information.

.....GO ON TO PAGE 15 FOR NEXT CLUSTER: PROGRAM MANAGEMENT

PART II (con't)

ADDITIONAL TASKS RELATED TO DATA HANDLING

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.....GO ON TO PART II, PAGE 16

123

PART I (con't)

TASKS RELATED TO PROGRAM AND AGENCY MANAGEMENT AND FACILITY OPERATION

Program and Agency Management

/ / 1. Establish treatment priorities--in order to manage unit service program.

/ / 2. Assign staff--in order to regulate staffing patterns.

/ / 3. Meet with representatives of other organizations, clarify related roles, systems and/or procedures--in order to develop coordinated, complimentary relationship.

/ / 4. Communicate safety and security regulations to staff and clients--in order to provide appropriate environment.

/ / 5. Plan physical plant development, construction, renovation, repair, and maintenance--in order to provide adequate and appropriate physical environment.

/ / 6. Purchase supplies and equipment--in order to provide materials for operation of facilities and treatment programs.

/ / 7. Plan, develop, and review budget--in order to provide and control financial resources.

/ / 8. Recruit, coordinate, and monitor volunteer and student activities--in order to manage resource.

/ / 9. Develop policy and/or procedural statements, occassionally with others--in order to establish routine or emergency operational guidelines.

/ / 10. Develop and carry out employee relation activities and policies--in order to enhance efficiency and morale.

/ / 11. Assign work to appropriate subordinates, indicate priorities--in order to distribute tasks and duties.

Personnel Management

/ / 12. Evaluate employee performance, using established agency methods--in order to rate and measure employee's work and recommend appropriate action.

/ / 13. Deal with grievances or conflicts between employees and/or union representatives, determine solutions to the problem(s)--in order to resolve issues.

/ / 14. Counsel employee with personal problem, such as being upset, having family problems, etc.--in order to restore job functioning.

/ / 15. Supervise work of subordinates--in order to assure high work standards.

/ / 16. Screen application and/or interview job applicant, using knowledge of position requirements--in order to select appropriate job applicant.

/ / 17. Provide information about open positions--in order to recruit potential employees/applicants.

.....GO ON TO PAGE 16

PART I (con't)

TASKS RELATED TO PROGRAM AND AGENCY MANAGEMENT AND FACILITY OPERATION (con't)

Facility Operation

/ / 18. Arrange personal work schedule (day, work, etc.), or materials--in order to plan efficient use of time.

/ / 19. Perform routine screening of visitors admitted to unit--in order to maintain environment.

/ / 20. Keep track of furniture, supplies, and equipment--in order to control property.

/ / 21. Maintain adequate inventory of forms--in order to provide records.

/ / 22. Route individual client through clinic or hearing according to established policy, ease client's anxieties as necessary--in order to promote efficient operations.

/ / 23. Receive/distribute and put up supplies--in order to manage materials.

/ / 24. Eliminate or report hazards--in order to provide safe environment.

/ / 25. Exchange information about events or details relating to shift operations--in order to provide orderly transfer of responsibility.

/ / 26. Arrange facility tour for individuals upon request--in order to plan visitation.

/ / 27. Receive and distribute donated articles, route same to appropriate locations--in order to furnish clients with supplementary goods.

.....NOW - GO TO PART II ON PAGE 2

Part II (con't)

ADDITIONAL TASKS RELATED TO PROGRAM AND AGENCY MANAGEMENT AND FACILITY OPERATION

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.....NOW - GO TO PART III ON PAGE 17

PART III PERCENTAGE OF TIME

This part of the SURVEY simply asks you to divide your job time (100%) among fourteen different clusters of tasks. You are to decide, as closely as you can, what percentage of your time (in an average month) you spend doing each type of task. Place your percentages in the boxes to the left of the description of the type of task.

NOTE: THE COMBINED PERCENTAGES OF YOUR ANSWERS SHOULD TOTAL 100%.

When you put in the percentage, always use two numbers even though it is less than ten percent.

For example, if you do not do the type of task at all: / 0 / 0 / %

If you spend 5% of your time: / 0 / 5 / %

If you spend 35% of your time: / 3 / 5 / %

- - - -

PART III (con't)

F. Skill Building - The major purpose of this activity is to increase the skill level, and thus, the life functioning of the client. The situation will usually be a therapeutic one, with the objective to enhance the daily living and/or social skills of the client. Activities can include coaching, teaching,
/ / /% and modeling.

G. Consulting - The major purpose of this activity is to identify and resolve problems of a technical nature. The relationship will usually be a collegial one and typically will take place in an organizational context or setting. Usually, the consultant provides information, clarifies problems, and issues, gives interpretations and advice which the consultee is free to accept or reject. It may involve conferences or meetings to receive or supply relevant information. Problems involving knowledge deficiencies
/ / /% may be identified and small-scale or informal instruction may be offered.

H. Teaching - The major purpose of this activity is to impart or receive information, increase awareness, and improve skills of staff. The content of the teaching process is usually technical in nature and the context will usually be organizational. Activities involve the formal preparation of a plan, set of objectives, a method or procedure, and evaluation of teaching/learning. Usually, methods and expected outcomes will be agreed-upon
/ / /% in advance.

I. Remediation - The major purpose of this activity is to restore clients to an original or "normative" level of functioning or adjustment. It may involve a high- or low-risk process focusing upon psycho-social functioning. It involves staged and planned, worker-controlled, therapeutic activities intended to enhance or restore normative functioning. A variety of strategies
/ / /% and/or modalities whose primary purpose is restorative are included.

J. Personal Care-Giving - The major purpose of this activity is custodial. It includes activities intended to provide the personal comfort and control
/ / /% necessary to maintain the physical or emotional well-being of the client.

K. Milieu Management - The major purpose of this activity is to enhance a stable environment to provide stability. It includes activities intended to control physical and social situations, in order to promote security, reduce hazards, provide support, and prevent deterioration from current
/ / /% levels of individual functioning.

L. Case Management - The major purpose of this activity is to plan, monitor, and evaluate services for particular clients. Case planning involves the analysis of assembled client data in order to make decisions regarding case disposition. A written plan or revision is generally developed which identifies problems and assigns responsibility for treatment. It ranges from the initial analysis at intake, through periodic monitoring and eval-
/ / /% uation, to termination of treatment and follow-up.

M. Data Handling - The major purpose of this activity is to collect and compile information relevant to clients, systems, and staff, and to conduct research.
Client data includes information needed for diagnosis and case planning, treatment, disposition, eligibility determination, statistical reporting, and financial control.
Systems data includes collecting and compiling information obtained from both internal and external sources for the purpose of program and financial planning and evaluation, policy determination, and program or institution-related administrative decision-making.
Staff data includes collecting and compiling information related to personnel processes, manning, and decision-making.
Research data includes statistically preparing and analyzing collected information related to or across groups of clients and treatment procedures
/ / /% or programs at all levels of sophistication.

.....GO ON TO PAGE 19

PART III (con't)

H. Program and Agency Management and Facility Operation -- The major purposes of these activities are decision-making, policy formation, and organizational operation at all levels, in all organizational contexts, and by all leadership styles.

Program and Agency Management includes the program and institutional planning, monitoring, and budgeting, and allocating of personnel and financial, and physical resources to service delivery and logistical support.

Personnel Management includes the entire range of personnel and supervisory functions: recruitment, classification, payroll and benefits, staff development, evaluation, grievances, awards, and discipline.

Facility Operation includes the administrative and logistical activities related to operation of and maintenance of an agency or institution for

/ / /% delivery of services to clients.

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1 0 0 % TOTAL (Please check your arithmetic to be sure that the TOTAL of time recorded equals 100%.)

.....GO ON TO PART IV, BELOW

PART IV HOW YOU GET INSTRUCTIONS

In this part, we are interested in how you typically find out the way things are to be done on your job. You are to indicate, in terms of percentages, how often you find out about WHEN and HOW tasks are to be done: (A) by READING things that have been written down, (B) by WORD OF MOUTH from other people, or (C) by using your head and YOUR OWN JUDGMENT.

We would like you to tell us how you generally get information about HOW your job is to be done and WHEN you are supposed to do various tasks. Now, think of your job. Think of all the times you do things. Mark down, in percentages, how you are told HOW and WHEN to do something. THE THREE PERCENTAGES SHOULD TOTAL 100%.

Because it is in writing (policies, procedures, guidelines, regulations).	/ / /%
Because someone tells you how or when to do it (supervisor, co-worker).	/ / /%
Because you figure it out yourself and rely on your own judgment.	/ / /%

(Please check your arithmetic) TOTAL: 1 0 0 %